

103D CONGRESS
1ST SESSION

S. 18

To provide improved access to health care, enhance informed individual choice regarding health care services, lower health care costs through the use of appropriate providers, improve the quality of health care, improve access to long-term care, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JANUARY 21 (legislative day, JANUARY 5), 1993

Mr. SPECTER introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To provide improved access to health care, enhance informed individual choice regarding health care services, lower health care costs through the use of appropriate providers, improve the quality of health care, improve access to long-term care, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Comprehensive Health Care Act of 1993”.

6 (b) TABLE OF CONTENTS.—The table of contents of
7 this Act is as follows:

TITLE I—HEALTH CARE INSURANCE REFORM PROVISIONS

Subtitle A—Model Health Care Insurance Benefits Plan

- Sec. 101. Model health care insurance benefits plan.
- Sec. 102. Definitions.

Subtitle B—Managed Care

- Sec. 111. Development of standards for managed care plans.
- Sec. 112. Preemption of provisions relating to managed care.

Subtitle C—Small Employer Purchasing Groups

- Sec. 121. Qualified small employer purchasing groups.
- Sec. 122. Preemption from insurance mandates for small employer purchasing groups.

Subtitle D—Insurance Market Reform

- Sec. 131. Failure to satisfy certain standards for health care insurance provided to small employers.

Subtitle E—Deduction for Health Insurance Costs of Self-Employed Individuals

- Sec. 141. Increase in deductible health insurance costs for self-employed individuals.

TITLE II—PRIMARY AND PREVENTIVE CARE SERVICES

- Sec. 201. Maternal and infant care coordination.
- Sec. 202. Reauthorization of certain programs providing primary and preventive care.
- Sec. 203. Comprehensive school health education program.
- Sec. 204. Comprehensive early childhood health education program.

TITLE III—DISCLOSURE OF CERTAIN INFORMATION TO BENEFICIARIES UNDER THE MEDICARE AND MEDICAID PROGRAMS

- Sec. 301. Regulations requiring disclosure of certain information to beneficiaries under the medicare and medicaid programs.
- Sec. 302. Outreach activities.

TITLE IV—PATIENT'S RIGHT TO DECLINE MEDICAL TREATMENT

- Sec. 401. Right to decline medical treatment.
- Sec. 402. Federal right enforceable in Federal courts.
- Sec. 403. Suicide and homicide.
- Sec. 404. Rights granted by States.
- Sec. 405. Effect on other laws.
- Sec. 406. Information provided to certain individuals.
- Sec. 407. Recommendations to the Congress on issues relating to a patient's right of self-determination.
- Sec. 408. Effective date.

TITLE V—PRIMARY AND PREVENTIVE CARE PROVIDERS

- Sec. 501. Increasing payments to certain nonphysician providers under the medicare program.
- Sec. 502. Requiring coverage of certain nonphysician providers under the medicaid program.
- Sec. 503. Medical student tutorial program grants.
- Sec. 504. General medical practice grants.
- Sec. 505. Payments for direct and indirect graduate medical education costs.

TITLE VI—MEDICARE PREFERRED PROVIDER DEMONSTRATION PROJECTS

- Sec. 601. Establishment of medicare primary and specialty preferred provider organization demonstration projects.

TITLE VII—COST CONTAINMENT

- Sec. 701. New drug clinical trials program.
- Sec. 702. Medical treatment effectiveness.
- Sec. 703. Health care cost control—expenditure targets.

TITLE VIII—LONG-TERM CARE

Subtitle A—Tax Treatment of Qualified Long-Term Care Insurance Policies

- Sec. 801. Amendment of 1986 Code.
- Sec. 802. Definitions of qualified long-term care insurance and premiums.
- Sec. 803. Treatment of qualified long-term care insurance as accident and health insurance for purposes of taxation of insurance companies.
- Sec. 804. Treatment of accelerated death benefits under life insurance contracts.

Subtitle B—Tax Incentives for Purchase of Qualified Long-Term Care Insurance

- Sec. 811. Credit for qualified long-term care premiums.
- Sec. 812. Deduction for expenses relating to qualified long-term care.
- Sec. 813. Exclusion from gross income of benefits received under qualified long-term care insurance.
- Sec. 814. Employer deduction for contributions made for long-term care insurance.
- Sec. 815. Inclusion of qualified long-term care insurance in cafeteria plans.
- Sec. 816. Exclusion from gross income for amounts withdrawn from individual retirement plans and section 401(k) plans for qualified long-term care premiums and expenses.
- Sec. 817. Exclusion from gross income for amounts received on cancellation of life insurance policies and used for qualified long-term care insurance.
- Sec. 818. Use of gain from sale of principal residence for purchase of qualified long-term health care insurance.

Subtitle C—Medicaid Amendments

- Sec. 821. Expansion of medicaid eligibility for long-term care benefits.
- Sec. 822. Effective date.

1 **TITLE I—HEALTH CARE INSUR-**
2 **ANCE REFORM PROVISIONS**
3 **Subtitle A—Model Health Care**
4 **Insurance Benefits Plan**

5 **SEC. 101. MODEL HEALTH CARE INSURANCE BENEFITS**
6 **PLAN.**

7 (a) IN GENERAL.—The Secretary shall request that
8 the NAIC—

9 (1) develop a model health care insurance bene-
10 fits plan that shall contain standards that entities
11 offering health care insurance policies should meet
12 with respect to the benefits and coverage provided
13 under such policies, and

14 (2) report to the Secretary on such standards,
15 not later than 1 year after the date of the enactment
16 of this Act.

17 If the NAIC develops such a plan by such date and the
18 Secretary finds that such plan implements the require-
19 ments of subsection (c), such plan shall be the model
20 health care insurance benefits plan under this Act.

21 (b) ROLE OF THE SECRETARY IN ABSENCE OF NAIC
22 PLAN.—If the NAIC fails to develop and report a model
23 health care insurance benefits plan by the date specified
24 in subsection (a) or the Secretary finds that such plan
25 does not implement the requirements of subsection (c), the

1 Secretary shall develop and publish such a plan, by not
2 later than 18 months after the date of the enactment of
3 this Act. Such plan shall then be the plan under this Act.

4 (c) CONTENTS.—The standards under the model ben-
5 efits plan should require—

6 (1) that coverage be provided under health care
7 insurance policies for basic hospital, medical and
8 surgical services, including preventive care services,
9 mental health services, and other ancillary services
10 determined appropriate by the Secretary;

11 (2) reasonable cost sharing by the beneficiaries
12 under such policies; and

13 (3) appropriate copayments and deductibles.

14 **SEC. 102. DEFINITIONS.**

15 As used in this title:

16 (1) HEALTH CARE INSURANCE.—The term
17 “health care insurance” means any hospital or medi-
18 cal expense incurred policy or certificate, hospital or
19 medical service plan contract, health maintenance
20 subscriber contract, multiple employer welfare ar-
21 rangement, other employee welfare plan (as defined
22 in the Employee Retirement Income Security Act of
23 1974), or any other health insurance arrangement,
24 and includes an employment-related reinsurance
25 plan, but does not include—

1 (A) a self-insured health care insurance
2 plan; or

3 (B) any of the following offered by an in-
4 surer—

5 (i) accident only, dental only, or dis-
6 ability income only insurance,

7 (ii) coverage issued as a supplement
8 to liability insurance,

9 (iii) worker's compensation or similar
10 insurance, or

11 (iv) automobile medical-payment in-
12 surance.

13 (2) MANAGED CARE PLAN.—The term “man-
14 aged care plan” means a health care insurance plan
15 in which the insurer offering such plan utilizes the
16 recommended standards developed under section 111
17 concerning the benefits and coverage under such
18 plan.

19 (3) MODEL BENEFITS PLAN.—The term “model
20 benefits plan” means the model health care insur-
21 ance benefits plan developed under section 101(a).

22 (4) NAIC.—The term “NAIC” means the Na-
23 tional Association of Insurance Commissioners.

24 (5) SECRETARY.—The term “Secretary” means
25 the Secretary of Health and Human Services.

1 (6) SMALL EMPLOYER.—

2 (A) IN GENERAL.—The term “small em-
 3 ployer” means any employer which, on an aver-
 4 age business day during the preceding taxable
 5 year, had more than 2 but less than 100 em-
 6 ployees.

7 (B) EMPLOYEE.—The term “employee”
 8 shall not include—

9 (i) a self-employed individual as de-
 10 fined in section 401(c)(1) of the Internal
 11 Revenue Code of 1986, or

12 (ii) an employee who works less than
 13 20 hours per week.

14 **Subtitle B—Managed Care**

15 **SEC. 111. DEVELOPMENT OF STANDARDS FOR MANAGED** 16 **CARE PLANS.**

17 (a) IN GENERAL.—Not later than 1 year after the
 18 date of the enactment of this Act, the Secretary, taking
 19 into account recommendations of the Managed Care Advi-
 20 sory Committee, shall develop recommended standards
 21 that insurers offering managed care plans should meet
 22 with respect to the benefits, coverage, and delivery systems
 23 provided under such plans. Such standards shall encom-
 24 pass the standards by which managed care entities
 25 operate.

1 (b) MANAGED CARE ADVISORY COMMITTEE.—

2 (1) ESTABLISHMENT.—There shall be estab-
3 lished a Managed Care Advisory Committee (herein-
4 after referred to as the “Committee”).

5 (2) MEMBERSHIP.—The Committee shall be
6 composed of individuals appointed by the Secretary,
7 representing the following:

8 (A) Consumers.

9 (B) Physicians.

10 (C) Nurses.

11 (D) Hospitals.

12 (E) Community-based providers.

13 (F) Organizations delivering managed care
14 services.

15 (G) Academia (with specific expertise in
16 managed care plans).

17 (H) Business management.

18 (I) Organized labor.

19 (3) COMPENSATION.—

20 (A) IN GENERAL.—Members of the Com-
21 mittee shall serve without compensation.

22 (B) EXPENSES, ETC., REIMBURSED.—
23 While away from their homes or regular places
24 of business on the business of the Committee,
25 the members may be allowed travel expenses,

1 including per diem in lieu of subsistence, as au-
 2 thorized by section 5703 of title 5, United
 3 States Code, for persons employed intermit-
 4 tently in Government service.

5 (C) APPLICATION OF ACT.—The provisions
 6 of the Federal Advisory Committee Act (5
 7 U.S.C. App.) shall not apply with respect to the
 8 Committee.

9 (D) SUPPORT.—The Secretary shall supply
 10 such necessary office facilities, office supplies,
 11 support services, and related expenses as nec-
 12 essary to carry out the functions of the
 13 Committee.

14 **SEC. 112. PREEMPTION OF PROVISIONS RELATING TO MAN-**
 15 **AGED CARE.**

16 In the case of a managed care plan meeting the rec-
 17 ommended standards developed under section 111 that is
 18 offered by an insurer, the following provisions of State law
 19 are preempted and may not be enforced against the man-
 20 aged care plan with respect to an insurer offering such
 21 plan:

22 (1) RESTRICTIONS ON REIMBURSEMENT RATES
 23 OR SELECTIVE CONTRACTING.—Any law that re-
 24 stricts the ability of the insurer to negotiate reim-
 25 bursement rates with health care providers or to

1 contract selectively with one provider or a limited
2 number of providers.

3 (2) RESTRICTIONS ON DIFFERENTIAL FINAN-
4 CIAL INCENTIVES.—Any law that limits the financial
5 incentives that the managed care plan may require
6 a beneficiary to pay when a nonplan provider is used
7 on a nonemergency basis.

8 (3) RESTRICTIONS ON UTILIZATION REVIEW
9 METHODS.—

10 (A) IN GENERAL.—Any law that—

11 (i) prohibits utilization review of any
12 or all treatments and conditions;

13 (ii) requires that such review be made
14 by a resident of the State in which the
15 treatment is to be offered or by an individ-
16 ual licensed in such State, or by a physi-
17 cian in any particular specialty or with any
18 board certified specialty of the same medi-
19 cal specialty as the provider whose services
20 are being rendered;

21 (iii) requires the use of specified
22 standards of health care practice in such
23 review or requires the disclosure of the
24 specific criteria used in such review;

1 (iv) requires payments to providers for
 2 the expenses of responding to utilization
 3 review requests; or

4 (v) imposes liability for delays in per-
 5 forming such review.

6 (B) CONSTRUCTION.—Nothing in subpara-
 7 graph (A)(ii) shall be construed as prohibiting
 8 a State from requiring that utilization review be
 9 conducted by a licensed health care profes-
 10 sional, or requiring that any appeal from such
 11 a review be made by a licensed physician or by
 12 a licensed physician in any particular specialty
 13 or with any board certified specialty of the
 14 same medical specialty as the provider whose
 15 services are being rendered.

16 (4) RESTRICTIONS ON BENEFITS.—Any law
 17 that mandates benefits under the managed care plan
 18 that are greater than the benefits recommended
 19 under the standards developed under section 111.

20 **Subtitle C—Small Employer** 21 **Purchasing Groups**

22 **SEC. 121. QUALIFIED SMALL EMPLOYER PURCHASING** 23 **GROUPS.**

24 (a) DEFINED.—For purposes of this title, an entity
 25 is a qualified small employer purchasing group if—

1 (1) the entity submits an application to the Sec-
2 retary at such time, in such form and containing
3 such information as the Secretary may require; and

4 (2) on the basis of information contained in the
5 application and any other information the Secretary
6 may require, the Secretary determines that—

7 (A) the entity is administered solely under
8 the authority and control of its member employ-
9 ers;

10 (B) the membership of the entity consists
11 solely of small employers (except that an em-
12 ployer member of the group may retain its
13 membership in the group if, after the Secretary
14 determines that the entity meets the require-
15 ments of this subsection, the number of employ-
16 ees of the employer member increases to more
17 than 100);

18 (C) with respect to each State in which its
19 members are located, the entity consists of not
20 fewer than 100 employers;

21 (D) at the time the entity submits its ap-
22 plication, the health care insurance plans with
23 respect to the employer members of the entity
24 are in compliance with applicable State laws

1 and the model benefits plan relating to such
2 plans;

3 (E) the health care insurance plans of the
4 entity and the employer members of the entity
5 are not self-insured plans;

6 (F) each enrollee in the program of the en-
7 tity may enroll with any participating carrier
8 that offers health care insurance coverage in
9 the geographic area in which the enrollee re-
10 sides; and

11 (G) such entity will be a nonprofit entity;
12 and

13 (3) such entity has a board of directors as de-
14 scribed in subsection (b) with authority to act as de-
15 scribed in subsection (c).

16 (b) OPERATIONS.—A small employer purchasing
17 group shall be administered by a board of directors. The
18 members of such board shall be elected by the employers
19 that are members of the group, and such board members
20 shall serve at the pleasure of the majority of such employ-
21 ers.

22 (c) DUTIES OF BOARD.—

23 (1) IN GENERAL.—The board shall have the au-
24 thority to—

1 (A) enter into contracts with carriers to
2 provide health care insurance coverage to eligi-
3 ble employees and their dependents;

4 (B) enter into other contracts as are nec-
5 essary or proper to carry out the provisions of
6 this subtitle;

7 (C) employ necessary staff;

8 (D) appoint committees as necessary to
9 provide technical assistance in the operation of
10 the entity's program;

11 (E) assess participating employers a rea-
12 sonable fee for necessary costs in connection
13 with the program;

14 (F) undertake activities necessary to ad-
15 minister the program including marketing and
16 publicizing the program and assuring carrier,
17 employer, and enrollee compliance with program
18 requirements;

19 (G) issue rules and regulations necessary
20 to carry out the purpose of this subtitle; and

21 (H) accept and expend funds received
22 through fees, grants, appropriations, or other
23 appropriate and lawful means.

24 (2) PROGRAM MANAGEMENT.—

1 (A) GEOGRAPHIC AREAS OF COVERAGE.—

2 The board shall establish geographic areas
3 within which participating carriers may offer
4 health care insurance coverage to eligible em-
5 ployees and dependents. The board shall con-
6 tract with sufficient numbers and types of car-
7 riers in an area to assure that employees have
8 a choice from among a reasonable number and
9 type of competing health care insurance car-
10 riers.

11 (B) CONTRACT REQUIREMENTS.—

12 (i) IN GENERAL.—The board shall
13 enter into contracts with qualified carriers
14 for the purpose of providing health care in-
15 surance coverage to eligible employees and
16 dependents, and shall pay qualified carriers
17 on at least a monthly basis at the con-
18 tracted rates.

19 (ii) GENERAL QUALIFICATIONS OF
20 CARRIERS.—Participating carriers shall be
21 qualified if such carriers have—

22 (I) adequate administrative man-
23 agement,

24 (II) financial solvency, and

1 (III) the ability to assume the
2 risk of providing and paying for cov-
3 ered services.

4 A participating carrier may utilize reinsur-
5 ance, provider risk sharing, and other ap-
6 propriate mechanisms to share a portion of
7 the risk described in subclause (III). The
8 board may establish risk adjustment mech-
9 anisms that can be utilized to address cir-
10 cumstances where a participating carrier
11 has a significantly disproportionate share
12 of high risk or low risk enrollees based
13 upon valid data provided by the carrier.
14 Any such risk adjustment mechanism may
15 be developed and applied only after con-
16 sultation with the participating carriers.

17 (C) PROGRAM STANDARDS.—The board
18 shall require that participating carriers that
19 contract with or employ health care providers
20 shall have mechanisms to accomplish at least
21 the following, satisfactory to the program:

- 22 (i) Review the quality of care covered.
23 (ii) Review the appropriateness of care
24 covered.
25 (iii) Provide accessible health services.

1 (D) UNIFORMITY OF BENEFITS.—The
2 board shall assure that participating carriers—

3 (i) shall offer substantially similar
4 benefits to enrollees in the program, except
5 that enrollees cost sharing required by par-
6 ticipating carriers may vary according to
7 the basic method of operation of the car-
8 rier, and

9 (ii) shall not vary rates to small em-
10 ployers or enrollees in the program on ac-
11 count of claim experience, health status, or
12 duration from issue.

13 (E) PAYMENT MECHANISM.—The board
14 shall establish a mechanism to collect premiums
15 from small employers, including remittance of
16 the enrollee's share of the premium.

17 (3) NOTIFICATION OF PROGRAM BENEFITS.—

18 The board shall use appropriate and efficient means
19 to notify employers of the availability of sponsored
20 health care insurance coverage under the program.

21 The board shall make available marketing materials
22 which accurately summarize the carriers' insurance
23 plans and rates which are offered through the pro-
24 gram. A participating carrier may contract with an
25 agent or broker to provide marketing, advertising, or

1 presentation proposals or otherwise disseminate in-
2 formation regarding coverage or services or rates of-
3 fered in connection with the program.

4 (4) CONDITIONS OF PARTICIPATION.—

5 (A) IN GENERAL.—The board shall estab-
6 lish conditions of participation for small em-
7 ployers and enrollees that—

8 (i) assure that the entity is a valid
9 small employer purchasing group and is
10 not formed for the purpose of securing
11 health care insurance coverage;

12 (ii) assure that individuals in the
13 group are not added for the purpose of se-
14 curing such coverage;

15 (iii) require that a specified percent-
16 age of employees and dependents obtain
17 health care insurance coverage;

18 (iv) require minimum employer con-
19 tributions; and

20 (v) require prepayment of premiums
21 or other mechanisms to assure that pay-
22 ment will be made for coverage.

23 (B) MINIMUM PARTICIPATION.—The board
24 may require participating employers to agree to
25 participate in the program for a specified mini-

1 mum period of time and may include in any
2 participation agreements with employers a re-
3 quirement for a financial deposit or provision
4 for a financial penalty, which would be invoked
5 in the event the employer violates the participa-
6 tion agreement.

7 (d) GRANTS.—

8 (1) AUTHORITY.—The Secretary may award
9 grants to qualified small employer purchasing
10 groups to assist such groups in paying the expendi-
11 tures associated with the formation and initial oper-
12 ations of such groups.

13 (2) APPLICATION.—To be eligible to receive a
14 grant under this subsection, a qualified small em-
15 ployer purchasing group shall request such a grant
16 as part of the application submitted by such group
17 under subsection (a)(1).

18 (3) AUTHORIZATION OF APPROPRIATIONS.—
19 There are authorized to be appropriated for award-
20 ing grants under this subsection such sums as may
21 be necessary.

22 (e) FREEDOM OF CONTRACT.—Nothing in this sub-
23 title shall be construed to prohibit a participating carrier
24 from offering health care insurance coverage to small em-

1 ployers that are not participating in the program of a
2 small employer purchasing group.

3 **SEC. 122. PREEMPTION FROM INSURANCE MANDATES FOR**
4 **SMALL EMPLOYER PURCHASING GROUPS.**

5 (a) FINDING.—The Congress finds that qualified
6 small employer purchasing groups organized for the pur-
7 pose of obtaining health insurance for the employer mem-
8 bers of such groups affect interstate commerce.

9 (b) PREEMPTION OF STATE MANDATES.—In the case
10 of a qualified small employer purchasing group, no provi-
11 sion of State law shall apply that requires the offering,
12 as part of the health care insurance plan with respect to
13 an employer member of such a group, of any services, cat-
14 egory of care, or services of any class or type of provider
15 that is in excess of that recommended under the model
16 benefit plan.

17 **Subtitle D—Insurance Market**
18 **Reform**

19 **SEC. 131. FAILURE TO SATISFY CERTAIN STANDARDS FOR**
20 **HEALTH CARE INSURANCE PROVIDED TO**
21 **SMALL EMPLOYERS.**

22 (a) IN GENERAL.—Subchapter L of chapter 1 of the
23 Internal Revenue Code of 1986 (relating to insurance
24 companies) is amended by adding at the end thereof the
25 following new part:

1 **“PART IV—HEALTH CARE INSURANCE PROVIDED**
 2 **TO SMALL EMPLOYERS**

“Sec. 850. Failure to satisfy standards for health care insurance of small employers.

“Sec. 850A. General issuance requirements.

“Sec. 850B. Specific contractual requirements.

“Sec. 850C. State compliance agreements.

“Sec. 850D. Definitions and other rules.

3 **“SEC. 850. FAILURE TO SATISFY CERTAIN STANDARDS FOR**
 4 **HEALTH CARE INSURANCE OF SMALL EM-**
 5 **PLOYERS.**

6 “(a) GENERAL RULE.—No health insurance contract
 7 issued to an eligible small employer shall be treated as
 8 a contract for purposes of section 807 or 832 if the issuer
 9 of such a contract fails to meet at any time during any
 10 taxable year—

11 “(1) the general issuance requirements of sec-
 12 tion 850A, or

13 “(2) the specific contractual requirements of
 14 section 850B.

15 “(b) LIMITATION.—

16 “(1) SECTION NOT TO APPLY WHERE FAILURE
 17 NOT DISCOVERED EXERCISING REASONABLE DILI-
 18 GENCE.—Subsection (a) shall not apply with respect
 19 to any failure for which it is established to the satis-
 20 faction of the Secretary that the person described in
 21 such subsection did not know, or exercising reason-

1 able diligence would not have known, that such fail-
2 ure existed.

3 “(2) SECTION NOT TO APPLY WHERE FAILURES
4 CORRECTED WITHIN 30 DAYS.—Subsection (a) shall
5 not apply with respect to any failure if—

6 “(A) such failure was due to reasonable
7 cause and not to willful neglect, and

8 “(B) such failure is corrected during the
9 30-day period beginning on the 1st date any of
10 the persons described in such subsection knew,
11 or exercising reasonable diligence would have
12 known, that such failure existed.

13 “(3) WAIVER BY SECRETARY.—In the case of a
14 failure which is due to reasonable cause and not to
15 willful neglect, the Secretary may waive the applica-
16 tion of subsection (a).

17 **“SEC. 850A. GENERAL ISSUANCE REQUIREMENTS.**

18 “(a) GENERAL RULE.—The requirements of this sec-
19 tion are met if a person meets—

20 “(1) the mandatory policy requirements of sub-
21 section (b),

22 “(2) the guaranteed issue requirements of sub-
23 section (c), and

24 “(3) the mandatory registration and disclosure
25 requirements of subsection (d).

1 “(b) MANDATORY POLICY REQUIREMENTS.—

2 “(1) IN GENERAL.—The requirements of this
3 subsection are met if any person issuing a health
4 care insurance contract to any eligible small em-
5 ployer makes available to such employer a health
6 care insurance contract which—

7 “(A) provides benefits and coverage con-
8 sistent with the model health care insurance
9 benefits plan developed under section 101 of the
10 Comprehensive Health Care Act of 1993, and

11 “(B) is for a term of not less than 12
12 months.

13 “(2) PRICING AND MARKETING REQUIRE-
14 MENTS.—The requirements of paragraph (1) are not
15 met unless—

16 “(A) the price at which the contract de-
17 scribed in paragraph (1) is made available is
18 not greater than the price for such contract de-
19 termined on the same basis as prices for other
20 health care insurance contracts within the same
21 class of business made available by the person
22 to eligible small employers, and

23 “(B) such contract is made available to eli-
24 gible small employers using at least the market-

1 ing methods and other sales practices which are
2 used in selling such other contracts.

3 “(c) GUARANTEED ISSUE.—

4 “(1) IN GENERAL.—The requirements of this
5 subsection are met if the person offering health care
6 insurance contracts to eligible small employers issues
7 such a contract to any eligible small employer seek-
8 ing to enter into such a contract.

9 “(2) FINANCIAL CAPACITY EXCEPTION.—Para-
10 graph (1) shall not require any person to issue a
11 health care insurance contract to the extent that the
12 issuance of such contract would result in such per-
13 son violating the financial solvency standards (if
14 any) established by the State in which such contract
15 is to be issued.

16 “(3) DELIVERY CAPACITY EXCEPTION.—Para-
17 graph (1) shall not require any person to issue a
18 health care insurance contract to the extent that the
19 issuance of such contract would result, upon dem-
20 onstration to the Secretary, in such person exceeding
21 such person’s administrative capacity to serve pre-
22 viously enrolled groups and individuals (and addi-
23 tional individuals who will be expected to enroll be-
24 cause of affiliation with such previously enrolled
25 groups).

1 “(4) EXCEPTION FOR CERTAIN EMPLOYERS.—

2 Paragraph (1) shall not apply to a failure to issue
3 a health care insurance contract to an eligible small
4 employer if—

5 “(A) such employer is unable to pay the
6 premium for such contract, or

7 “(B) in the case of an eligible small em-
8 ployer with fewer than 15 employees, such em-
9 ployer fails to enroll a minimum percentage of
10 the employer’s eligible employees for coverage
11 under such contract, so long as such percentage
12 is enforced uniformly for all eligible small em-
13 ployers of comparable size.

14 “(5) EXCEPTION FOR ALTERNATIVE STATE
15 PROGRAMS.—

16 “(A) IN GENERAL.—Paragraph (1) shall
17 not apply if the State in which the health care
18 insurance contract is issued—

19 “(i) has a program which—

20 “(I) assures the availability of
21 health care insurance contracts to eli-
22 gible small employers through the eq-
23 uitable distribution of high risk
24 groups among all persons offering
25 such contracts to such employers, and

1 “(II) is consistent with a model
2 program developed by the NAIC;

3 “(ii) has a qualified State-run reinsur-
4 ance program, or

5 “(iii) has a program which the Sec-
6 retary of Health and Human Services has
7 determined assures all eligible small em-
8 ployers in the State an opportunity to pur-
9 chase a health care insurance contract
10 without regard to any risk characteristic.

11 “(B) REINSURANCE PROGRAM.—

12 “(i) PROGRAM REQUIREMENTS.—For
13 purposes of subparagraph (A)(ii), a State-
14 run reinsurance program is qualified if
15 such program is one of the NAIC reinsur-
16 ance program models developed under
17 clause (ii) or is a variation of one of such
18 models, as approved by the Secretary of
19 Health and Human Services.

20 “(ii) MODELS.—Not later than 120
21 days after the date of the enactment of the
22 Comprehensive Health Care Act of 1993,
23 the NAIC shall develop several models for
24 a reinsurance program, including options
25 for program funding.

1 “(d) MANDATORY REGISTRATION AND DISCLOSURE
2 REQUIREMENTS.—The requirements of this subsection
3 are met if the person offering health care insurance con-
4 tracts to eligible small employers in any State—

5 “(1) registers with the State commissioner or
6 superintendent of insurance or other State authority
7 responsible for regulation of health insurance,

8 “(2) fully discloses the rating practices for
9 small employer health care insurance contracts at
10 the time such person offers a health care insurance
11 contract to an eligible small employer, and

12 “(3) fully discloses the terms for renewal of the
13 contract at the time of the offering of such contract
14 and at least 90 days before the expiration of such
15 contract.

16 **“SEC. 850B. SPECIFIC CONTRACTUAL REQUIREMENTS.**

17 “(a) GENERAL RULE.—The requirements of this sec-
18 tion are met if the following requirements are met:

19 “(1) The coverage requirements of subsection
20 (b).

21 “(2) The rating requirements of subsection (c).

22 “(b) COVERAGE REQUIREMENTS.—

23 “(1) IN GENERAL.—The requirements of this
24 subsection are met with respect to any health care

1 insurance contract if, under the terms and operation
2 of the contract, the following requirements are met:

3 “(A) GUARANTEED ELIGIBILITY.—No eli-
4 gible employee (and the spouse or any depend-
5 ent child of the employee eligible for coverage)
6 may be excluded from coverage under the con-
7 tract.

8 “(B) LIMITATIONS ON COVERAGE OF PRE-
9 EXISTING CONDITIONS.—Any limitation under
10 the contract on any preexisting condition—

11 “(i) may not extend beyond the 6-
12 month period beginning with the date an
13 insured is first covered by the contract,
14 and

15 “(ii) may only apply to preexisting
16 conditions which manifested themselves, or
17 for which medical care or advice was
18 sought or recommended, during the 3-
19 month period preceding the date an in-
20 sured is first covered by the contract.

21 “(C) GUARANTEED RENEWABILITY.—

22 “(i) IN GENERAL.—The contract must
23 be renewed at the election of the eligible
24 small employer unless the contract is ter-
25 minated for cause.

1 “(ii) CAUSE.—For purposes of this
2 subparagraph, the term ‘cause’ means—

3 “(I) nonpayment of the required
4 premiums;

5 “(II) fraud or misrepresentation
6 of the employer or, with respect to
7 coverage of individual insureds, the
8 insureds or their representatives;

9 “(III) noncompliance with the
10 contract’s minimum participation re-
11 quirements;

12 “(IV) noncompliance with the
13 contract’s employer contribution re-
14 quirements; or

15 “(V) repeated misuse of a pro-
16 vider network provision in the con-
17 tract.

18 “(2) WAITING PERIODS.—Paragraph (1)(A)
19 shall not apply to any period an employee is ex-
20 cluded from coverage under the contract solely by
21 reason of a requirement applicable to all employees
22 that a minimum period of service with the employer
23 is required before the employee is eligible for such
24 coverage.

1 “(3) DETERMINATION OF PERIODS FOR RULES
2 RELATING TO PREEXISTING CONDITIONS.—For pur-
3 poses of paragraph (1)(B), the date on which an in-
4 sured is first covered by a contract shall be the
5 earlier of—

6 “(A) the date on which coverage under
7 such contract begins, or

8 “(B) the first day of any continuous
9 period—

10 “(i) during which the insured was cov-
11 ered under one or more other health insur-
12 ance arrangements, and

13 “(ii) which does not end more than
14 120 days before the date employment with
15 the employer begins.

16 “(4) CESSATION OF SMALL EMPLOYER HEALTH
17 INSURANCE BUSINESS.—

18 “(A) IN GENERAL.—Except as otherwise
19 provided in this paragraph, a person shall not
20 be treated as failing to meet the requirements
21 of paragraph (1)(C) if such person terminates
22 the class of business which includes the health
23 care insurance contract.

24 “(B) NOTICE REQUIREMENT.—Subpara-
25 graph (A) shall apply only if the person gives

1 notice of the decision to terminate at least 90
2 days before the expiration of the contract.

3 “(C) 5-YEAR MORATORIUM.—If, within 5
4 years of the year in which a person terminates
5 a class of business under subparagraph (A),
6 such person establishes a new class of business,
7 the issuance of such contracts in that year shall
8 be treated as a failure to which this section
9 applies.

10 “(D) TRANSFERS.—If, upon a failure to
11 renew a contract to which subparagraph (A)
12 applies, a person offers to transfer such con-
13 tract to another class of business, such transfer
14 must be made without regard to risk character-
15 istics.

16 “(c) RATING REQUIREMENTS.—

17 “(1) IN GENERAL.—The requirements of this
18 subsection are met if—

19 “(A) the requirements of paragraphs (2)
20 and (3) are met, and

21 “(B) any increase in any premium rate
22 under the renewal contract over the correspond-
23 ing rate under the health care insurance con-
24 tract being renewed does not exceed the appli-
25 cable annual adjusted increase.

1 “(2) LIMIT ON VARIATION OF PREMIUMS BE-
2 TWEEN CLASSES OF BUSINESS.—

3 “(A) IN GENERAL.—The requirements of
4 this paragraph are met if the index rate for a
5 rating period for any class of business of the in-
6 surer does not exceed the index rate for any
7 other class of business by more than 20 per-
8 cent.

9 “(B) EXCEPTIONS.—Subparagraph (A)
10 shall not apply to a class of business if—

11 “(i) the class is one for which the in-
12 surer does not reject, and never has re-
13 jected, eligible small employers included
14 within the class of business or otherwise el-
15 igible employees and dependents who enroll
16 on a timely basis, based upon risk charac-
17 teristics,

18 “(ii) the insurer does not transfer,
19 and never has transferred, a health care
20 insurance contract involuntarily into or out
21 of the class of business, and

22 “(iii) the class of business is currently
23 available for purchase.

24 “(3) LIMIT ON VARIATION IN PREMIUM RATES
25 WITHIN A CLASS OF BUSINESS.—The requirements

1 of this paragraph are met if the premium rates
 2 charged during a rating period to eligible small em-
 3 ployers with similar case characteristics (other than
 4 risk characteristics) for the same or similar cov-
 5 erage, or the rates which could be charged to such
 6 employers under the rating system for that class of
 7 business, do not vary from the index rate by more
 8 than 20 percent of the index rate.

9 “(4) APPLICABLE ANNUAL ADJUSTED IN-
 10 CREASE.—For purposes of paragraph (1)(B)—

11 “(A) IN GENERAL.—The applicable annual
 12 adjusted increase is an amount equal to the
 13 sum of—

14 “(i) the applicable percentage of the
 15 premium rate under the health care insur-
 16 ance contract being renewed, plus

17 “(ii) any increase in the rate under
 18 the renewal contract due to any change in
 19 coverage or to any change of case charac-
 20 teristics (other than risk characteristics),
 21 plus

22 “(iii) 5 percentage points.

23 “(B) APPLICABLE PERCENTAGE.—

1 “(i) IN GENERAL.—For purposes of
2 subparagraph (A), the applicable percent-
3 age is the percentage (if any) by which—

4 “(I) the premium rate for newly
5 issued contracts for substantially simi-
6 lar coverage for an employer with
7 similar case characteristics (other
8 than risk characteristics) as the em-
9 ployer under the health care insurance
10 contract (determined on the 1st day
11 of the rating period applicable to such
12 contracts), exceeds

13 “(II) such rate on the 1st day of
14 the rating period applicable to the
15 contract being renewed.

16 “(ii) CASES WHERE NO NEW BUSI-
17 NESS.—If no new contracts are being is-
18 sued for a class of business during any rat-
19 ing period, the applicable percentage shall
20 be the percentage (if any) by which the
21 base premium rate determined under para-
22 graph (5)(B) with respect to the renewal
23 contract exceeds such rate for the contract
24 to be renewed.

1 “(5) DEFINITIONS.—For purposes of this sub-
2 section—

3 “(A) INDEX RATE.—The term ‘index rate’
4 means, with respect to a class of business, the
5 arithmetic average of the applicable base pre-
6 mium rate and the corresponding highest pre-
7 mium rate for that class.

8 “(B) BASE PREMIUM RATE.—The term
9 ‘base premium rate’ means, for each class of
10 business for each rating period, the lowest pre-
11 mium rate which could have been charged
12 under a rating system for that class of business
13 by the insurer to eligible small employers with
14 similar case characteristics (other than risk
15 characteristics) for health care insurance con-
16 tracts with the same or similar coverage.

17 **“SEC. 850C. STATE COMPLIANCE AGREEMENTS.**

18 “(a) AGREEMENTS.—The Secretary of Health and
19 Human Services may enter into an agreement with any
20 State—

21 “(1) to apply the standards set by the NAIC
22 for health care insurance contracts in lieu of the re-
23 quirements of this subchapter, and

24 “(2) to provide for the State to make the initial
25 determination as to whether a person is in compli-

1 ance with such standards for purposes of applying
2 the sanctions under section 850.

3 “(b) STANDARDS.—An agreement may be entered
4 into under subsection (a)(1) only if—

5 “(1) the chief executive officer of the State re-
6 quests that such agreement be entered into,

7 “(2) the Secretary of Health and Human Serv-
8 ices determines that the NAIC standards to be ap-
9 plied under the agreement will carry out the pur-
10 poses of this subchapter, and

11 “(3) the Secretary determines that the NAIC
12 standards to be applied under the agreement will
13 apply to substantially all health care insurance
14 contracts issued in such State to eligible small
15 employers.

16 “(c) TERMINATION.—The Secretary of Health and
17 Human Services shall terminate any agreement if the Sec-
18 retary determines that the application of NAIC standards
19 by the State ceases to carry out the purposes of this sub-
20 chapter.

21 “(d) NAIC STANDARDS.—Not later than 270 days
22 after the date of the enactment of the Comprehensive
23 Health Care Act of 1993, the NAIC shall develop stand-
24 ards which provide for requirements substantially similar
25 to the requirements of this subchapter.

1 **“SEC. 850D. DEFINITIONS AND OTHER RULES.**

2 “For purposes of this part—

3 “(1) HEALTH CARE INSURANCE.—The term
4 ‘health care insurance’ means any hospital or medi-
5 cal expense incurred policy or certificate, hospital or
6 medical service plan contract, health maintenance
7 subscriber contract, multiple employer welfare ar-
8 rangement, other employee welfare plan (as defined
9 in the Employee Retirement Income Security Act of
10 1974), or any other health insurance arrangement,
11 and includes an employment-related reinsurance
12 plan, but does not include—

13 “(A) a self-insured health care insurance
14 plan; or

15 “(B) any of the following offered by an in-
16 surer—

17 “(i) accident only, dental only, or dis-
18 ability income only insurance,

19 “(ii) coverage issued as a supplement
20 to liability insurance,

21 “(iii) worker’s compensation or simi-
22 lar insurance, or

23 “(iv) automobile medical-payment in-
24 surance.

25 “(2) CLASS OF BUSINESS.—

1 “(A) IN GENERAL.—Except as provided in
2 subparagraph (B), the term ‘class of business’
3 means, with respect to health care insurance
4 provided to eligible small employers, all health
5 care insurance provided to such employers.

6 “(B) ESTABLISHMENT OF GROUPINGS.—

7 “(i) IN GENERAL.—An issuer may es-
8 tablish separate classes of business with re-
9 spect to health care insurance provided to
10 eligible small employers but only if such
11 classes are based on one or more of the
12 following:

13 “(I) Business marketed and sold
14 through persons not participating in
15 the marketing and sale of such insur-
16 ance to other eligible small employers.

17 “(II) Business acquired from
18 other insurers as a distinct grouping.

19 “(III) Business provided through
20 an association of not less than 20 eli-
21 gible small employers which was es-
22 tablished for purposes other than ob-
23 taining insurance.

24 “(IV) Business related to man-
25 aged care plans (as defined in section

1 102(2) of the Comprehensive Health
2 Care Act of 1993.

3 “(V) Any other business which
4 the Secretary of Health and Human
5 Services determines needs to be sepa-
6 rately grouped to prevent a substan-
7 tial threat to the solvency of the
8 insurer.

9 “(ii) EXCEPTION ALLOWED.—Except
10 as provided in subparagraph (C), an in-
11 surer may not establish more than one dis-
12 tinct group of eligible small employers for
13 each category specified in clause (i).

14 “(C) SPECIAL RULE.—An insurer may es-
15 tablish up to 2 groups under each category in
16 subparagraph (A) or (B) to account for dif-
17 ferences in characteristics (other than dif-
18 ferences in plan benefits) of health insurance
19 plans that are expected to produce substantial
20 variation in health care costs.

21 “(3) CHARACTERISTICS.—

22 “(A) IN GENERAL.—The term ‘characteris-
23 tics’ means, with respect to any insurance rat-
24 ing system, the factors used in determining
25 rates.

1 “(B) RISK CHARACTERISTICS.—The term
2 ‘risk characteristics’ means factors related to
3 the health risks of individuals, including health
4 status, prior claims experience, the duration
5 since the date of issue of a health insurance
6 plan or arrangement, industry, and occupation.

7 “(C) GEOGRAPHIC FACTORS.—

8 “(i) IN GENERAL.—In applying geo-
9 graphic location as a characteristic, an in-
10 surer may not use for purposes of this sub-
11 chapter areas smaller than 3-digit postal
12 zip code areas.

13 “(ii) STUDY AND REPORT.—Not later
14 than 120 days after the date of the enact-
15 ment of the Comprehensive Health Care
16 Act of 1993, the Comptroller General of
17 the United States shall study and report to
18 the Congress concerning—

19 “(I) insurance industry practices
20 in determining the geographic bound-
21 aries of communities used for setting
22 rates,

23 “(II) the feasibility and desirabil-
24 ity of establishing standardized geo-

1 graphic communities for setting rates,
2 and

3 “(III) the effect such standard-
4 ized geographic communities would
5 have on rates charged small employ-
6 ers.

7 “(4) ELIGIBLE SMALL EMPLOYER.—

8 “(A) IN GENERAL.—The term ‘eligible
9 small employer’ means any person which, on an
10 average business day during the preceding tax-
11 able year, had more than 2 but less than 50
12 employees.

13 “(B) AGGREGATION RULES.—All members
14 of the same controlled group of corporations
15 (within the meaning of section 52(a)) and all
16 persons under common control (within the
17 meaning of section 52(b)) shall be treated as 1
18 person.

19 “(C) EMPLOYEE.—The term ‘employee’
20 shall not include—

21 “(i) a self-employed individual as de-
22 fined in section 401(c)(1), or

23 “(ii) an employee who works less than
24 20 hours per week.

1 “(5) NAIC.—The term ‘NAIC’ means the Na-
2 tional Association of Insurance Commissioners.”.

3 (b) CONFORMING AMENDMENT.—Subchapter L of
4 chapter 1 of the Internal Revenue Code of 1986 is amend-
5 ed by adding at the end thereof the following new item:

 “Part IV. Health Care Insurance Provided to Small Employers.”.

6 (c) EFFECTIVE DATES.—

7 (1) IN GENERAL.—The amendments made by
8 this section shall apply to contracts issued, or re-
9 newed, after the date of the enactment of this Act.

10 (2) GUARANTEED ISSUE.—The provisions of
11 section 850A(c) of the Internal Revenue Code of
12 1986, as added by this section, shall apply to con-
13 tracts which are issued, or renewed, after the date
14 which is 18 months after the date of the enactment
15 of this Act.

16 (3) PREMIUM RANGE.—In the case of any con-
17 tract in effect on the date of the enactment of this
18 Act, the provisions of section 850B(c)(1)(A) of such
19 Code, as added by this section, shall not apply to the
20 premiums under such contract or any renewal con-
21 tract for benefits provided during the period begin-
22 ning on such date and ending on the last day of the
23 2nd plan year beginning after such date.

1 **Subtitle E—Deduction for Health**
 2 **Insurance Costs of Self-Em-**
 3 **ployed Individuals**

4 **SEC. 141. INCREASE IN DEDUCTIBLE HEALTH INSURANCE**
 5 **COSTS FOR SELF-EMPLOYED INDIVIDUALS.**

6 (a) IN GENERAL.—Paragraph (1) of section 162(l)
 7 of the Internal Revenue Code of 1986 (relating to special
 8 rules for health insurance costs of self-employed individ-
 9 uals) is amended by striking “25 percent” and inserting
 10 “100 percent”.

11 (b) REPEAL OF TERMINATION PROVISION.—Para-
 12 graph (6) of section 162(l) of such Code (relating to termi-
 13 nation) is repealed.

14 (c) CONFORMING AMENDMENT.—Section 110(a) of
 15 the Tax Extension Act of 1991 is amended by striking
 16 paragraph (2).

17 (d) EFFECTIVE DATE.—The amendments made by
 18 this section shall apply to taxable years beginning after
 19 June 30, 1992.

20 **TITLE II—PRIMARY AND**
 21 **PREVENTIVE CARE SERVICES**

22 **SEC. 201. MATERNAL AND INFANT CARE COORDINATION.**

23 (a) PURPOSE.—It is the purpose of this section to
 24 assist States in the development and implementation of
 25 coordinated, multidisciplinary, and comprehensive primary

1 health care and social services, and health and nutrition
2 education programs, designed to improve maternal and
3 child health.

4 (b) GRANTS FOR IMPLEMENTATION OF PROGRAMS.—

5 (1) AUTHORITY.—The Secretary of Health and
6 Human Services (hereafter referred to in this section
7 as the “Secretary”) is authorized to award grants to
8 States to enable such States to plan and implement
9 coordinated, multidisciplinary, and comprehensive
10 primary health care and social service programs tar-
11 geted to pregnant women and infants.

12 (2) ELIGIBILITY.—To be eligible to receive a
13 grant under this section, a State shall—

14 (A) prepare and submit to the Secretary
15 an application at such time, in such manner,
16 and containing such information as the Sec-
17 retary may require;

18 (B) provide assurances that under the pro-
19 gram established with amounts received under a
20 grant, individuals will have access (without any
21 barriers) to comprehensive family planning
22 counseling, pregnancy testing, prenatal care,
23 delivery, intrapartum and postpartum care, pe-
24 diatric care for infants, and social services as
25 appropriate, including outreach activities, home

1 visits, child care, transportation, risk assess-
2 ment, nutrition counseling, dental care, mental
3 health services, substance abuse services, serv-
4 ices relating to HIV infection, and prevention
5 counseling;

6 (C) provide assurances that under the pro-
7 gram individuals will have access, without any
8 barriers, to the full range of pediatric services
9 provided by pediatric nurse practitioners and
10 clinical nurse specialists, including in-home
11 services for low birth weight babies;

12 (D) as part of the State application, sub-
13 mit a plan for providing incentive payments of
14 up to \$500 to pregnant women who—

15 (i) have not attained age 20;

16 (ii) are at risk of having low birth
17 weight babies;

18 (iii) agree to attend not less than 5
19 prenatal visits and 1 postnatal visit; and

20 (iv) agree to attend a requisite num-
21 ber of prenatal care and parenting classes,
22 as determined by the State;

23 (E) as part of the State application, sub-
24 mit a plan for the coordination and maximiza-
25 tion of existing and proposed Federal and State

1 resources, including amounts provided under
2 the medicaid program under title XIX of the
3 Social Security Act, the special supplemental
4 food program under section 17 of the Child Nu-
5 trition Act of 1966, family planning programs,
6 substance abuse programs, State maternal and
7 child health programs funded under title V of
8 the Social Security Act, community and mi-
9 grant health center programs under the Public
10 Health Service Act, and other publicly, or where
11 practicable, privately supported programs;

12 (F) demonstrate that the major service
13 providers to be involved, including private non-
14 profit entities committed to improving maternal
15 and infant health, are committed to and in-
16 volved in the program to be funded with
17 amounts received under the grant;

18 (G) with respect to States with high infant
19 mortality rates among minority populations,
20 demonstrate the involvement of major health,
21 multiservice, professional, or civic group rep-
22 resentatives of such minority groups in the
23 planning and implementation of the State pro-
24 gram; and

1 (H) demonstrate that health promotion
2 and outreach activities under the State program
3 are targeted to women of childbearing age, par-
4 ticularly those at risk for having low birth
5 weight babies.

6 (3) TERM OF GRANT.—A grant awarded under
7 this subsection shall be for a period of 5 years.

8 (4) USE OF AMOUNTS.—Amounts received by a
9 State under a grant awarded under this subsection
10 shall be used to establish a State program to provide
11 coordinated, multidisciplinary, and comprehensive
12 primary health care and social services, and health
13 and nutrition education program services, that are
14 designed to improve maternal and child health.

15 (5) AUTHORIZATION OF APPROPRIATIONS.—
16 There are authorized to be appropriated to carry out
17 this subsection, \$100,000,000 for fiscal year 1994,
18 \$300,000,000 for fiscal year 1995, and
19 \$500,000,000 for each of the fiscal years 1996
20 through 1998.

21 (c) MODEL HEALTH AND NUTRITION EDUCATION
22 CURRICULA.—

23 (1) AUTHORITY.—The Secretary, in conjunction
24 with the Secretary of Education and the Secretary
25 of Agriculture, is authorized to award grants, on a

1 competitive basis, to public or nonprofit private enti-
 2 ties to enable such entities to develop model health
 3 and nutrition education curricula for children in
 4 grades kindergarten through twelfth.

5 (2) APPLICATION.—To be eligible to receive a
 6 grant under paragraph (1), an entity shall prepare
 7 and submit to the Secretary an application at such
 8 time, in such manner, and containing such informa-
 9 tion as the Secretary may require.

10 (3) CURRICULA.—Curricula developed under
 11 paragraph (1) should be consistent with the goals of
 12 “Healthy People 2000: National Health Promotion
 13 and Disease Prevention Objectives”, published by
 14 the Department of Health and Human Services in
 15 September 1990, and shall address the cultural and
 16 lifestyle realities of racial and ethnic minority popu-
 17 lations.

18 (4) AUTHORIZATION OF APPROPRIATIONS.—
 19 There are authorized to be appropriated to carry out
 20 this subsection, \$10,000,000 for fiscal year 1994.

21 **SEC. 202. REAUTHORIZATION OF CERTAIN PROGRAMS PRO-**
 22 **VIDING PRIMARY AND PREVENTIVE CARE.**

23 (a) IMMUNIZATION PROGRAMS.—Section
 24 317(j)(1)(A) of the Public Health Service Act (42 U.S.C.
 25 247b(j)(1)(A)) is amended—

1 (1) by striking “and such sums” and inserting
2 “such sums”; and

3 (2) by striking “each of the fiscal years 1992
4 through 1995” and inserting “each of the fiscal
5 years 1992 and 1993, \$380,000,000 for fiscal year
6 1994, and such sums as may be necessary for each
7 of the fiscal years 1995 through 1998”.

8 (b) TUBERCULOSIS PREVENTION GRANTS.—Section
9 317(j)(2) of the Public Health Service Act (42 U.S.C.
10 247b(j)(2)) is amended—

11 (1) by striking “and such sums” and inserting
12 “such sums”; and

13 (2) by striking “each of the fiscal years 1992
14 through 1995” and inserting “each of the fiscal
15 years 1992 and 1993, \$30,000,000 for fiscal year
16 1994, and such sums as may be necessary for each
17 of the fiscal years 1995 through 1998”.

18 (c) SEXUALLY TRANSMITTED DISEASES.—Section
19 318(d)(1) of the Public Health Service Act (42 U.S.C.
20 247c(d)(1)) is amended—

21 (1) by striking “and such sums” and inserting
22 “such sums”; and

23 (2) by inserting before the first period the fol-
24 lowing: “\$125,000,000 for fiscal year 1994, and

1 such sums as may be necessary for each of the fiscal
2 years 1995 through 1998”.

3 (d) MIGRANT HEALTH CENTERS.—Section
4 329(h)(1)(A) of the Public Health Service Act (42 U.S.C.
5 254b(h)(1)(A)) is amended by striking “and 1991, and
6 such sums as may be necessary for each of the fiscal years
7 1992 through 1994” and inserting “through 1993,
8 \$80,000,000 for fiscal year 1994, and such sums as may
9 be necessary for each of the fiscal years 1995 through
10 1998”.

11 (e) COMMUNITY HEALTH CENTERS.—Section
12 330(g)(1)(A) of the Public Health Service Act (42 U.S.C.
13 254c(g)(1)(A)) is amended by striking “and 1991, and
14 such sums as may be necessary for each of the fiscal years
15 1992 through 1994” and inserting “through 1993,
16 \$700,000,000 for fiscal year 1994, and such sums as may
17 be necessary for each of the fiscal years 1995 through
18 1998”.

19 (f) HEALTH CARE SERVICES FOR THE HOMELESS.—
20 Section 340(q)(1) of the Public Health Service Act (42
21 U.S.C. 256(q)(1)) is amended by striking “and such
22 sums” and all that follows through the period and insert-
23 ing “\$90,000,000 for fiscal year 1994, and such sums as
24 may be necessary for each of the fiscal years 1995 through
25 1998.”.

1 (g) FAMILY PLANNING PROJECT GRANTS.—Section
2 1001(d) of the Public Health Service Act (42 U.S.C.
3 300(d)) is amended—

4 (1) by striking “and \$158,400,000” and insert-
5 ing “\$158,400,000”; and

6 (2) by inserting before the period the following:
7 “, \$200,000,000 for fiscal year 1994, and such sums
8 as may be necessary for each of the fiscal years
9 1995 through 1998”.

10 (h) BREAST AND CERVICAL CANCER PREVENTION.—
11 Section 1509(a) of the Public Health Service Act (42
12 U.S.C. 300n–5(a)) is amended—

13 (1) by striking “and such sums” and inserting
14 “such sums”; and

15 (2) by striking “for each of the fiscal years
16 1992 and 1993” and inserting “for each of the fiscal
17 years 1992 and 1993, \$100,000,000 for fiscal year
18 1994, and such sums as may be necessary for each
19 of the fiscal years 1995 through 1998”.

20 (i) PREVENTIVE HEALTH AND HEALTH SERVICES
21 BLOCK GRANT.—Section 1901(a) of the Public Health
22 Service Act (42 U.S.C. 300w(a)) is amended by striking
23 “\$205,000,000” and inserting “\$235,000,000”.

1 (j) HIV EARLY INTERVENTION.—Section 2655 of the
2 Public Health Service Act (42 U.S.C. 300ff–55) is
3 amended—

4 (1) by striking “and such sums” and inserting
5 “such sums”; and

6 (2) by striking “each of the fiscal years 1992
7 through 1995” and inserting “each of fiscal years
8 1992 and 1993, \$310,000,000 for fiscal year 1994,
9 and such sums as may be necessary for each of the
10 fiscal years 1995 through 1998”.

11 (k) MATERNAL AND CHILD HEALTH SERVICES
12 BLOCK GRANT.—Section 501(a) of the Social Security
13 Act (42 U.S.C. 701(a)) is amended by striking
14 “\$686,000,000 for fiscal year 1990 and each fiscal year
15 thereafter” and inserting “\$800,000,000 for fiscal year
16 1994, and such sums as may be necessary in each of the
17 fiscal years 1995 through 1998”.

18 **SEC. 203. COMPREHENSIVE SCHOOL HEALTH EDUCATION**
19 **PROGRAM.**

20 Section 4605 of the Elementary and Secondary Edu-
21 cation Act of 1965 (20 U.S.C. 3155) is amended to read
22 as follows:

1 **“SEC. 4605. COMPREHENSIVE SCHOOL HEALTH EDUCATION**
2 **PROGRAMS.**

3 “(a) PURPOSE.—It is the purpose of this section to
4 establish a comprehensive school health education and pre-
5 vention program for elementary and secondary school
6 students.

7 “(b) PROGRAM AUTHORIZED.—The Secretary,
8 through the Office of Comprehensive School Health Edu-
9 cation established in subsection (e), shall award grants to
10 States from allotments under subsection (c) to enable such
11 States to—

12 “(1) award grants to local or intermediate edu-
13 cational agencies, and consortia thereof, to enable
14 such agencies or consortia to establish, operate and
15 improve local programs of comprehensive health edu-
16 cation and prevention, early health intervention, and
17 health education, in elementary and secondary
18 schools (including preschool, kindergarten, inter-
19 mediate, and junior high schools); and

20 “(2) develop training, technical assistance and
21 coordination activities for the programs assisted pur-
22 suant to paragraph (1).

23 “(c) RESERVATIONS AND STATE ALLOTMENTS.—

24 “(1) RESERVATIONS.—From the sums appro-
25 priated pursuant to the authority of subsection (f)
26 for any fiscal year, the Secretary shall reserve—

1 “(A) 1 percent for payments to Guam,
2 American Samoa, the Virgin Islands, the Re-
3 public of the Marshall Islands, the Federated
4 States of Micronesia, the Northern Mariana Is-
5 lands, and the Republic of Palau, to be allotted
6 in accordance with their respective needs; and

7 “(B) 1 percent for payments to the Bureau
8 of Indian Affairs.

9 “(2) STATE ALLOTMENTS.—From the remain-
10 der of the sums not reserved under paragraph (1),
11 the Secretary shall allot to each State an amount
12 which bears the same ratio to the amount of such
13 remainder as the school-age population of the State
14 bears to the school-age population of all States, ex-
15 cept that no State shall be allotted less than an
16 amount equal to 0.5 percent of such remainder.

17 “(3) REALLOTMENT.—The Secretary may
18 reallot any amount of any allotment to a State to
19 the extent that the Secretary determines that the
20 State will not be able to obligate such amount within
21 2 years of allotment. Any such reallotment shall be
22 made on the same basis as an allotment under para-
23 graph (2).

24 “(d) USE OF FUNDS.—Grant funds provided to local
25 or intermediate educational agencies, or consortia thereof,

1 under this section may be used to improve elementary and
2 secondary education in the areas of—

3 “(1) personal health and fitness;

4 “(2) prevention of chronic diseases;

5 “(3) prevention and control of communicable
6 diseases;

7 “(4) nutrition;

8 “(5) substance use and abuse;

9 “(6) accident prevention and safety;

10 “(7) community and environmental health;

11 “(8) mental and emotional health;

12 “(9) parenting and the challenges of raising
13 children; and

14 “(10) the effective use of the health services
15 delivery system.

16 “(e) OFFICE OF COMPREHENSIVE SCHOOL HEALTH
17 EDUCATION.—The Secretary shall establish within the Of-
18 fice of the Secretary an Office of Comprehensive School
19 Health Education which shall have the following respon-
20 sibilities:

21 “(1) To recommend mechanisms for the coordi-
22 nation of school health education programs con-
23 ducted by the various departments and agencies of
24 the Federal Government.

1 “(2) To advise the Secretary on formulation of
2 school health education policy within the Depart-
3 ment of Education.

4 “(3) To disseminate information on the benefits
5 to health education of utilizing a comprehensive
6 health curriculum in schools.

7 “(f) AUTHORIZATION OF APPROPRIATIONS.—

8 “(1) IN GENERAL.—There are authorized to be
9 appropriated \$50,000,000 for fiscal year 1994 and
10 such sums as may be necessary for each of the fiscal
11 years 1995 and 1996 to carry out this section.

12 “(2) AVAILABILITY.—Funds appropriated pur-
13 suant to the authority of paragraph (1) in any fiscal
14 year shall remain available for obligation and ex-
15 penditure until the end of the fiscal year succeeding
16 the fiscal year for which such funds were appro-
17 priated.”.

18 **SEC. 204. COMPREHENSIVE EARLY CHILDHOOD HEALTH**
19 **EDUCATION PROGRAM.**

20 (a) PURPOSE.—It is the purpose of this section to
21 establish a comprehensive early childhood health education
22 program.

23 (b) PROGRAM.—The Secretary of Health and Human
24 Services shall conduct a program of awarding grants to
25 agencies conducting Head Start training to enable such

1 agencies to provide training and technical assistance to
2 Head Start teachers and other child care providers. Such
3 program shall—

4 (1) establish a training system through the
5 Head Start agencies and organizations conducting
6 Head Start training for the purpose of enhancing
7 teacher skills and providing comprehensive early
8 childhood health education curriculum;

9 (2) enable such agencies and organizations to
10 provide training to day care providers in order to
11 strengthen the skills of the early childhood workforce
12 in providing health education;

13 (3) provide technical support for health edu-
14 cation programs and curricula; and

15 (4) provide cooperation with other early child-
16 hood providers to ensure coordination of such pro-
17 grams and the transition of students into the public
18 school environment.

19 (c) USE OF FUNDS.—Grant funds under this section
20 may be used to provide training and technical assistance
21 in the areas of—

22 (1) personal health and fitness;

23 (2) prevention of chronic diseases;

24 (3) prevention and control of communicable dis-
25 eases;

- 1 (4) dental health;
- 2 (5) nutrition;
- 3 (6) substance use and abuse;
- 4 (7) accident prevention and safety;
- 5 (8) community and environmental health;
- 6 (9) mental and emotional health; and
- 7 (10) strengthening the role of parent involve-
- 8 ment.

9 (d) RESERVATION FOR INNOVATIVE PROGRAMS.—
10 The Secretary shall reserve 5 percent of the funds appro-
11 priated pursuant to the authority of subsection (e) in each
12 fiscal year for the development of innovative model health
13 education programs or curricula.

14 (e) AUTHORIZATION OF APPROPRIATIONS.—There
15 are authorized to be appropriated \$40,000,000 for fiscal
16 year 1994 and such sums as may be necessary for each
17 of the fiscal years 1995 and 1996 to carry out this section.

1 **TITLE III—DISCLOSURE OF CER-**
 2 **TAIN INFORMATION TO BENE-**
 3 **FICIARIES UNDER THE MEDI-**
 4 **CARE AND MEDICAID PRO-**
 5 **GRAMS**

6 **SEC. 301. REGULATIONS REQUIRING DISCLOSURE OF CER-**
 7 **TAIN INFORMATION TO BENEFICIARIES**
 8 **UNDER THE MEDICARE AND MEDICAID PRO-**
 9 **GRAMS.**

10 Part A of title XI of the Social Security Act (42
 11 U.S.C. 1301 et seq.) is amended by adding at the end
 12 the following new section:

13 “DISCLOSURE OF CERTAIN INFORMATION TO BENE-
 14 FICIARIES UNDER THE MEDICARE AND MEDICAID
 15 PROGRAMS

16 “SEC. 1144. (a) ANNUAL REPORTS.—

17 “(1) INSTITUTIONAL HEALTH CARE PROVID-
 18 ERS.—

19 “(A) IN GENERAL.—The Secretary shall
 20 issue regulations requiring that each institu-
 21 tional health care provider receiving payment
 22 for services provided under title XVIII or XIX
 23 shall make an annual report available to the re-
 24 cipients of services under such title.

1 “(B) CONTENTS OF REPORT.—The annual
2 report referred to in subparagraph (A) shall in-
3 clude—

4 “(i) mortality rates relating to serv-
5 ices provided to individuals, including inci-
6 dence and outcomes of surgical and other
7 invasive procedures;

8 “(ii) nosocomial infection rates;

9 “(iii) a list of routine preoperative
10 tests and other frequently performed medi-
11 cal tests, including blood tests, chest x-
12 rays, magnetic resonance imaging, comput-
13 erized axial tomography, urinalysis, and
14 heart catherizations, and the cost of such
15 tests;

16 “(iv) the number and types of mal-
17 practice claims against the provider de-
18 cided or settled for the year; and

19 “(v) such other information as the
20 Secretary shall require.

21 “(2) NONINSTITUTIONAL HEALTH CARE PRO-
22 VIDERS.—

23 “(A) IN GENERAL.—The Secretary shall
24 issue regulations requiring that each
25 noninstitutional provider receiving payment for

1 services provided under title XVIII or XIX shall
2 make an annual report available to the recipi-
3 ents of services under such title.

4 “(B) CONTENTS OF REPORT.—The report
5 referred to in subparagraph (A) shall include—

6 “(i) information regarding the provid-
7 er’s education, experience, qualifications,
8 board certification, and license to provide
9 health care services, including a list of the
10 States in which such provider is licensed
11 and any limitations on such provider’s
12 license;

13 “(ii) any disciplinary actions taken
14 against the provider by any health care fa-
15 cility, State medical agency, or medical or-
16 ganization which result in a finding of im-
17 proper conduct;

18 “(iii) any malpractice action against
19 the provider decided or settled;

20 “(iv) a disclosure of any ownership in-
21 terest the provider may have in any health
22 care facility, laboratory, or health care
23 supply company; and

24 “(v) such other information as the
25 Secretary shall require.

1 “(b) DISCLOSURE OF INFORMATION REGARDING
2 HEALTH CARE PROCEDURES AND FORMS.—

3 “(1) INFORMATION REGARDING HEALTH CARE
4 PROCEDURES AND FORMS.—The Secretary shall
5 issue regulations requiring that each institutional
6 and noninstitutional health care provider receiving
7 payment for services under title XVIII or XIX shall
8 make available any forms required in connection
9 with the receipt of services under such title which
10 consist of any diagnostic, surgical, or other invasive
11 procedure, prior to the performance of such proce-
12 dure.

13 “(2) INFORMATION PROVIDED BEFORE PER-
14 FORMANCE OF PROCEDURE.—The Secretary shall
15 issue regulations requiring each institutional and
16 noninstitutional health care provider receiving pay-
17 ment for services provided under title XVIII or XIX
18 to disclose to any individual receiving any surgical,
19 palliative, or other health care procedure or any
20 drug therapy or other treatment, the following infor-
21 mation prior to the performance of such procedure
22 or treatment:

23 “(A) The nature of the procedure or treat-
24 ment.

1 “(B) A description of the procedure or
2 treatment.

3 “(C) The risk and benefits associated with
4 the procedure or treatment.

5 “(D) The success rate for the procedure or
6 treatment generally, and for the provider.

7 “(E) The provider’s cost range for the pro-
8 cedure or treatment.

9 “(F) Any alternative treatment which may
10 be available to such individual.

11 “(G) Any known side effects of any medi-
12 cations required in connection with the proce-
13 dure or treatment.

14 “(H) The interactive effect of the complete
15 regimen of medications associated with the pro-
16 cedure.

17 “(I) The availability of the information
18 under this subsection and under subsections (a)
19 and (c).

20 “(J) Such other information as the Sec-
21 retary shall require.

22 “(3) EMERGENCIES.—The Secretary shall issue
23 regulations with respect to the waiver of any require-
24 ment established under paragraphs (1) and (2) in a
25 case where emergency health care is needed.

1 “(c) PATIENT’S RIGHT TO REFUSE INFORMATION
 2 AND TREATMENT.—The Secretary shall issue regulations
 3 requiring each institutional and noninstitutional health
 4 care provider receiving payment for services provided
 5 under title XVIII or XIX to inform any individual receiv-
 6 ing services under such title of such individual’s right—

7 “(1) to refuse any information which is avail-
 8 able to such individual under the regulations de-
 9 scribed in subsections (a) and (b);

10 “(2) to refuse any procedure or treatment;

11 “(3) to refuse attendance by any such provider;

12 or

13 “(4) to leave the premises of any such provider.

14 “(d) DEFINITIONS.—As used in this section—

15 “(1) INSTITUTIONAL HEALTH CARE PRO-
 16 VIDER.—The term ‘institutional health care pro-
 17 vider’ means any hospital, clinic, skilled nursing fa-
 18 cility, comprehensive outpatient rehabilitation facil-
 19 ity, home health agency, hospice program, or other
 20 facility receiving payment for services provided
 21 under title XVIII or XIX, as determined by the
 22 Secretary.

23 “(2) NONINSTITUTIONAL HEALTH CARE PRO-
 24 VIDER.—The term ‘noninstitutional health care pro-
 25 vider’ means any physician, physician assistant,

1 nurse practitioner, certified nurse midwife, certified
2 registered nurse anesthetist, or other individual re-
3 ceiving payment for services provided under title
4 XVIII or XIX, as determined by the Secretary.

5 “(e) COMPLIANCE.—

6 “(1) PENALTIES FOR FAILURE TO COMPLY.—
7 The Secretary shall issue regulations establishing
8 appropriate penalties for any failure to comply with
9 the regulations issued under this section.

10 “(2) WAIVER OF COMPLIANCE.—The Secretary
11 may waive any of the requirements under the regula-
12 tions issued under this section if a health care pro-
13 vider demonstrates that such requirements will re-
14 sult in an undue burden on such provider.”.

15 **SEC. 302. OUTREACH ACTIVITIES.**

16 (a) MEDICARE PROGRAM.—

17 (1) GRANTS TO NONPROFIT PRIVATE ENTITIES
18 FOR OUTREACH ACTIVITIES.—

19 (A) AUTHORITY.—The Secretary of Health
20 and Human Services (hereafter referred to in
21 this paragraph as the “Secretary”), is author-
22 ized to award grants, on a competitive basis, to
23 nonprofit private entities to enable such entities
24 to develop outreach activities to inform bene-
25 ficiaries under title XVIII of the Social Security

1 Act of the information available to such bene-
2 ficiaries pursuant to regulations issued by the
3 Secretary under section 1144 of the Social Se-
4 curity Act as added by section 311 of this Act.

5 (B) APPLICATION.—To be eligible to re-
6 ceive a grant under subparagraph (A), an entity
7 shall prepare and submit to the Secretary an
8 application at such time, in such manner, and
9 containing such information as the Secretary
10 may require.

11 (C) AUTHORIZATION OF APPROPRIA-
12 TIONS.—There are authorized to be appro-
13 priated to carry out this section, \$5,000,000 for
14 fiscal year 1994, \$5,000,000 for fiscal year
15 1995, and \$5,000,000 for fiscal year 1996.

16 (2) OUTREACH THROUGH NOTICE OF MEDICARE
17 BENEFITS.—Section 1804 of the Social Security Act
18 (42 U.S.C. 1395b-2) is amended—

19 (A) in paragraph (2), by striking “, and”
20 and inserting a comma,

21 (B) in paragraph (3), by striking the pe-
22 riod and inserting “, and”, and

23 (C) by inserting after paragraph (3), the
24 following new paragraph:

1 “(4) a description of the information available
2 to beneficiaries under this title pursuant to regula-
3 tions issued by the Secretary under section 1144.”.

4 (b) MEDICAID PROGRAM.—

5 (1) IN GENERAL.—Section 1902(a) of the So-
6 cial Security Act (42 U.S.C. 1396a(a)), is amend-
7 ed—

8 (A) by striking “and” at the end of para-
9 graph (54),

10 (B) by striking the period at the end of
11 paragraph (58) (as added by section
12 4751(a)(1)(C) of the Omnibus Budget Rec-
13 onciliation Act of 1990) and inserting a semi-
14 colon,

15 (C) by redesignating the second paragraph
16 (58) (as added by section 4752(c)(1)(C) of the
17 Omnibus Budget Reconciliation Act of 1990) as
18 paragraph (59) and by striking the period at
19 the end and inserting “; and”, and

20 (D) by adding at the end the following new
21 paragraph:

22 “(60) provide for an outreach program inform-
23 ing individuals who receive medical assistance under
24 this title of the information available to such individ-

1 uals pursuant to regulations issued by the Secretary
2 under section 1144.”.

3 (2) EFFECTIVE DATE.—

4 (A) IN GENERAL.—Paragraph (1) shall
5 apply to calendar quarters beginning on or after
6 January 1, 1994.

7 (B) GENERAL RULE.—In the case of a
8 State which the Secretary determines requires
9 State legislation (other than legislation author-
10 izing or appropriating funds) in order to comply
11 with paragraph (1), the State shall not be re-
12 garded as failing to comply with such para-
13 graph solely on the basis of its failure to meet
14 the requirements of such paragraph before the
15 first day of the first calendar quarter beginning
16 after the close of the first regular session of the
17 State legislature that begins after the date of
18 the enactment of this Act. For purposes of the
19 previous sentence, in the case of a State that
20 has a 2-year legislative session, each year of
21 such session shall be deemed to be a separate
22 regular session of the State legislature.

1 **TITLE IV—PATIENT’S RIGHT TO**
2 **DECLINE MEDICAL TREATMENT**

3 **SEC. 401. RIGHT TO DECLINE MEDICAL TREATMENT.**

4 (a) RIGHTS OF COMPETENT ADULTS.—

5 (1) IN GENERAL.—Except as provided in para-
6 graph (2), a State may not restrict the right of a
7 competent adult to consent to, or to decline, medical
8 treatment.

9 (2) LIMITATIONS.—

10 (A) AFFECT ON THIRD PARTIES.—A State
11 may impose limitations on the right of a com-
12 petent adult to decline treatment if such limita-
13 tions protect third parties (including minor chil-
14 dren) from harm.

15 (B) TREATMENT WHICH IS NOT MEDI-
16 CALLY INDICATED.—Nothing in this section
17 shall be construed to require that any individual
18 be offered, or that any individual may demand,
19 medical treatment which the health care pro-
20 vider does not have available, or which is futile,
21 or which is otherwise not medically indicated.

22 (b) RIGHTS OF INCAPACITATED ADULTS.—

23 (1) IN GENERAL.—Notwithstanding incapacity,
24 each adult has a right to consent to, or to decline,
25 medical treatment. Except as provided in subsection

1 (a)(2)(A), States may not restrict the right to con-
 2 sent to, or to decline, medical treatment as exercised
 3 by an adult through the documents specified in this
 4 subsection, or through similar documents or other
 5 written methods of directive which clearly and con-
 6 vincingly evidence the adult's treatment choices.

7 (2) ADVANCE DIRECTIVES AND POWERS OF AT-
 8 TORNEY.—

9 (A) IN GENERAL.—In order to facilitate
 10 the communication, despite incapacity, of an
 11 adult's treatment choices, the Secretary of
 12 Health and Human Services (hereafter in this
 13 title referred to as the "Secretary"), in con-
 14 sultation with the Attorney General, shall de-
 15 velop a national advance directive form that—

16 (i) shall not limit or otherwise restrict,
 17 except as provided in subsection (a)(2)(A),
 18 an adult's right to consent to, or to de-
 19 cline, medical treatment; and

20 (ii) shall, at minimum—

21 (I) provide the means for an
 22 adult to declare such adult's own
 23 treatment choices in the event of a
 24 terminal condition;

1 (II) provide the means for an
2 adult to declare, at such adult's op-
3 tion, treatment choices in the event of
4 other conditions (such as persistent
5 vegetative state) which are chronic
6 and debilitating, which are medically
7 incurable, and from which such adult
8 likely will not recover; and

9 (III) provide the means by which
10 an adult may, at such adult's option,
11 declare such adult's wishes with re-
12 spect to all forms of medical treat-
13 ment, including forms of medical
14 treatment such as the provision of nu-
15 trition and hydration by artificial
16 means which may be, in some cir-
17 cumstances, relatively nonburdensome.

18 (B) NATIONAL DURABLE POWER OF AT-
19 TORNEY FORM.—The Secretary, in consultation
20 with the Attorney General, shall develop a na-
21 tional durable power of attorney form for health
22 care decisionmaking. The form shall provide a
23 means for any adult to designate another adult
24 or adults to exercise the same decisionmaking

1 powers which would, under State law, otherwise
2 be exercised by next of kin.

3 (C) HONORED BY ALL HEALTH CARE PRO-
4 VIDERS.—The national advance directive and
5 durable power of attorney forms developed by
6 the Secretary shall be honored by all health
7 care providers.

8 (D) LIMITATIONS.—No individual shall be
9 required to execute an advance directive. This
10 title makes no presumption concerning the in-
11 tention of an individual who has not executed
12 an advance directive. An advance directive shall
13 be sufficient, but not necessary, proof of an
14 adult's treatment choices with respect to the
15 circumstances addressed in the advance direc-
16 tive.

17 (3) DEFINITION.—For purposes of this sub-
18 section, the term “incapacity” means the inability to
19 understand the nature and consequences of health
20 care decisions (including the intended benefits and
21 foreseeable risks of, and alternatives to, proposed
22 treatment options), and to reach informed decisions
23 concerning health care. Individuals who are incapaci-
24 tated include adjudicated incompetents and individ-
25 uals who have not been adjudicated incompetent but

1 who, nonetheless, lack the capacity to formulate or
2 communicate decisions concerning health care.

3 (c) HEALTH CARE PROVIDERS.—

4 (1) IN GENERAL.—No health care provider may
5 provide treatment to an adult contrary to the adult's
6 wishes as expressed personally, by an advance direc-
7 tive as provided for in subsection (b)(2), or by a
8 similar written advance directive form or another
9 written method of directive which clearly and con-
10 vincingly evidence the adult's treatment choices. A
11 health provider who acts in good faith pursuant to
12 the preceding sentence shall be immune from crimi-
13 nal or civil liability or discipline for professional mis-
14 conduct.

15 (2) HEALTH CARE PROVIDERS UNDER THE
16 MEDICARE AND MEDICAID PROGRAMS.—Any health
17 care provider who knowingly provides services to an
18 adult contrary to the adult's wishes as expressed
19 personally, by an advance directive as provided for
20 in subsection (b)(2), or by a similar written advance
21 directive form or another written method of directive
22 which clearly and convincingly evidence the adult's
23 treatment choices, shall be denied payment for such
24 services under titles XVIII and XIX of the Social
25 Security Act.

1 (3) TRANSFERS.—Health care providers who
2 object to the provision of medical care in accordance
3 with an adult’s wishes shall transfer the adult to the
4 care of another health care provider.

5 (d) DEFINITION.—For purposes of this section, the
6 term “adult” means an individual who is 18 years of age
7 or older.

8 **SEC. 402. FEDERAL RIGHT ENFORCEABLE IN FEDERAL**
9 **COURTS.**

10 The rights recognized in this title may be enforced
11 by filing a civil action in an appropriate district court of
12 the United States.

13 **SEC. 403. SUICIDE AND HOMICIDE.**

14 Nothing in this title shall be construed to permit, con-
15 done, authorize, or approve suicide or mercy killing, or any
16 affirmative act to end a human life.

17 **SEC. 404. RIGHTS GRANTED BY STATES.**

18 Nothing in this title shall impair or supersede rights
19 granted by State law which exceed the rights recognized
20 by this title.

21 **SEC. 405. EFFECT ON OTHER LAWS.**

22 (a) IN GENERAL.—Except as specified in subsection
23 (b), written policies and written information adopted by
24 health care providers pursuant to sections 4206 and 4751
25 of the Omnibus Budget Reconciliation Act of 1990 (Public

1 Law 101–508), shall be modified within 6 months of en-
 2 actment of this title to conform to the provisions of this
 3 title.

4 (b) DELAY PERIOD FOR UNIFORM FORMS.—Health
 5 care providers shall modify any written forms distributed
 6 as written information under sections 4206 and 4751 of
 7 the Omnibus Budget Reconciliation Act of 1990 (Public
 8 Law 101–508) not later than 6 months after promulgation
 9 of the forms referred to in subparagraphs (A) and (B)
 10 of section 401(b)(2) by the Secretary.

11 **SEC. 406. INFORMATION PROVIDED TO CERTAIN INDIVID-**
 12 **UALS.**

13 The Secretary shall provide on a periodic basis writ-
 14 ten information regarding an individual’s right to consent
 15 to, or to decline, medical treatment as provided in this
 16 title to individual’s who are beneficiaries under titles II,
 17 XVI, XVIII, and XIX of the Social Security Act.

18 **SEC. 407. RECOMMENDATIONS TO THE CONGRESS ON IS-**
 19 **SUES RELATING TO A PATIENT’S RIGHT OF**
 20 **SELF-DETERMINATION.**

21 Not later than 180 days after the date of the enact-
 22 ment of this Act the Secretary shall provide recommenda-
 23 tions to the Congress concerning the medical, legal, ethi-
 24 cal, social, and educational issues related to this title. In

1 developing recommendations under this section the Sec-
 2 retary shall address the following issues:

3 (1) the contents of the forms referred to in sub-
 4 paragraphs (A) and (B) of section 401(b)(2);

5 (2) issues pertaining to the education and train-
 6 ing of health care professionals concerning patients'
 7 self-determination rights;

8 (3) issues pertaining to health care profes-
 9 sionals' duties with respect to patients' rights, and
 10 health care professionals' roles in identifying, assess-
 11 ing, and presenting for patient consideration medi-
 12 cally indicated treatment options; and

13 (4) such other issues as the Secretary may
 14 identify.

15 **SEC. 408. EFFECTIVE DATE.**

16 This title shall take effect on the date that is 6
 17 months after the date of enactment of this Act.

18 **TITLE V—PRIMARY AND**
 19 **PREVENTIVE CARE PROVIDERS**

20 **SEC. 501. INCREASING PAYMENTS TO CERTAIN**
 21 **NONPHYSICIAN PROVIDERS UNDER THE**
 22 **MEDICARE PROGRAM.**

23 (a) INCREASE IN PAYMENTS TO NURSE PRACTITION-
 24 ERS, CLINICAL NURSE SPECIALISTS, CERTIFIED NURSE
 25 MIDWIVES, AND PHYSICIAN ASSISTANTS.—

1 (1) IN GENERAL.—Section 1833(a)(1) of the
2 Social Security Act (42 U.S.C. 1395l(a)(1)) is
3 amended—

4 (A) in subparagraph (K), by striking “80
5 percent” and all that follows through “physi-
6 cian)” and inserting “97 percent of the fee
7 schedule amount provided under section 1848
8 for the same service performed by a physician”;

9 (B) by redesignating subparagraph (M)
10 the second place it appears and subparagraph
11 (N), as subparagraphs (N) and (O), respec-
12 tively; and

13 (C) by amending subparagraph (N), as re-
14 designated, to read as follows: “(N) with re-
15 spect to services described in section
16 1861(s)(2)(K) (relating to services provided by
17 a nurse practitioner, clinical nurse specialist, or
18 physician assistant) the amounts paid shall be
19 97 percent of the fee schedule amount provided
20 under section 1848 for the same service per-
21 formed by a physician,”.

22 (2) NURSE PRACTITIONERS AND PHYSICIAN AS-
23 SISTANTS.—Section 1842(b)(12) of such Act (42
24 U.S.C. 1395u(b)(12)) is amended to read as follows:

1 “(12) With respect to services described in clauses
2 (i), (ii), or (iv) of section 1861(s)(2)(K) (relating to physi-
3 cian assistants and nurse practitioners)—

4 “(A) payment under this part may only be
5 made on an assignment-related basis; and

6 “(B) the prevailing charges determined under
7 paragraph (3) shall not exceed—

8 “(i) in the case of services performed as an
9 assistant at surgery, 97 percent of the amount
10 that would otherwise be recognized if performed
11 by a physician who is serving as an assistant at
12 surgery, or

13 “(ii) in other cases, 97 percent of the fee
14 schedule amount specified in section 1848 for
15 such services performed by physicians who are
16 not specialists.”.

17 (3) DIRECT PAYMENT FOR ALL NURSE PRACTI-
18 TIONERS OR CLINICAL NURSE SPECIALISTS.—Sec-
19 tion 1832(a)(2)(B)(iv) of such Act (42 U.S.C.
20 1395k(a)(2)(B)(iv)) is amended by striking “pro-
21 vided in a rural area (as defined in section
22 1886(d)(2)(D))”.

23 (4) REMOVAL OF RESTRICTIONS ON SET-
24 TINGS.—Section 1861(s)(2)(K) of such Act (42
25 U.S.C. 1395x(s)(2)(K)) is amended—

1 (A) in clause (i), by striking “(I) in a hos-
2 pital” and all that follows through “professional
3 shortage area,”;

4 (B) in clause (ii), by striking “in a skilled”
5 and all that follows through “1919(a)”; and

6 (C) in clause (iii), by striking “in a rural”
7 and all that follows through “(d)(2)(D))”.

8 (b) BONUS PAYMENT FOR SERVICES PROVIDED IN
9 HEALTH PROFESSIONAL SHORTAGE AREAS.—Section
10 1833(m) of the Social Security Act (42 U.S.C. 1395l(m))
11 is amended—

12 (1) by inserting “(1)” after “(m)”; and

13 (2) by adding at the end the following new
14 paragraph:

15 “(2) In the case of services of a nurse practitioner,
16 clinical nurse specialist, physician assistant, certified
17 nurse midwife, or certified registered nurse anesthetist
18 furnished to an individual described in paragraph (1) in
19 an area that is a health professional shortage area as de-
20 scribed in such paragraph, in addition to the amount oth-
21 erwise paid under this part, there shall also be paid to
22 such service provider (or to an employer in the cases de-
23 scribed in subparagraph (C) of section 1842(b)(6)) (on a
24 monthly or quarterly basis) from the Federal Supple-
25 mentary Medical Trust Fund an amount equal to 10 per-

1 cent of the payment amount for such services under this
2 part.”.

3 **SEC. 502. REQUIRING COVERAGE OF CERTAIN**
4 **NONPHYSICIAN PROVIDERS UNDER THE**
5 **MEDICAID PROGRAM.**

6 Section 1905(a) of the Social Security Act (42 U.S.C.
7 1396d(a)) is amended—

8 (1) in paragraph (21), by striking “; and” and
9 inserting a semicolon;

10 (2) in paragraph (24), by striking the period at
11 the end and inserting a semicolon;

12 (3) by redesignating paragraphs (22), (23), and
13 (24) as paragraphs (25), (22), and (23), respec-
14 tively;

15 (4) by inserting after paragraph (23) the fol-
16 lowing new paragraph:

17 “(24) services furnished by a physician assist-
18 ant, nurse practitioner, clinical nurse specialist (as
19 defined in section 1861(aa)(5)), and certified reg-
20 istered nurse anesthetist (as defined in section
21 1861(bb)(2)); and”;

22 (5) by striking the semicolon at the end of
23 paragraph (25), as redesignated, and inserting a pe-
24 riod; and

1 (6) by transferring and inserting paragraph
2 (25), as redesignated, after paragraph (24).

3 **SEC. 503. MEDICAL STUDENT TUTORIAL PROGRAM**
4 **GRANTS.**

5 Part C of title VII of the Public Health Service Act
6 is amended by adding at the end thereof the following new
7 section:

8 **“SEC. 753. MEDICAL STUDENT TUTORIAL PROGRAM**
9 **GRANTS.**

10 “(a) ESTABLISHMENT.—The Secretary shall estab-
11 lish a program to award grants to eligible schools of medi-
12 cine or osteopathic medicine to enable such schools to pro-
13 vide medical students for tutorial programs or as partici-
14 pants in clinics designed to interest high school or college
15 students in careers in general medical practice.

16 “(b) APPLICATION.—To be eligible to receive a grant
17 under this section, a school of medicine or osteopathic
18 medicine shall prepare and submit to the Secretary an ap-
19 plication at such time, in such manner, and containing
20 such information as the Secretary may require, including
21 assurances that the school will use amounts received under
22 the grant in accordance with subsection (c).

23 “(c) USE OF FUNDS.—

24 “(1) IN GENERAL.—Amounts received under a
25 grant awarded under this section shall be used to—

1 “(A) fund programs under which students
2 of the grantee are provided as tutors for high
3 school and college students in the areas of
4 math, science, health promotion and prevention,
5 first aide, nutrition and prenatal care;

6 “(B) fund programs under which students
7 of the grantee are provided as participants in
8 clinics and seminars in the areas described in
9 paragraph (1); and

10 “(C) conduct summer institutes for high
11 school and college students to promote careers
12 in medicine.

13 “(2) DESIGN OF PROGRAMS.—The programs,
14 institutes and other activities conducted by grantees
15 under paragraph (1) shall be designed to—

16 “(A) give medical students desiring to
17 practice general medicine access to the local
18 community;

19 “(B) provide information to high school
20 and college students concerning medical school
21 and the general practice of medicine; and

22 “(C) promote careers in general medicine.

23 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
24 are authorized to be appropriated to carry out this section,

1 \$5,000,000 for fiscal year 1994, and such sums as may
2 be necessary for fiscal year 1995.”.

3 **SEC. 504. GENERAL MEDICAL PRACTICE GRANTS.**

4 Part C of title VII of the Public Health Service Act
5 (as amended by section 503) is further amended by adding
6 at the end thereof the following new section:

7 **“SEC. 754. GENERAL MEDICAL PRACTICE GRANTS.**

8 “(a) ESTABLISHMENT.—The Secretary shall estab-
9 lish a program to award grants to eligible public or private
10 nonprofit schools of medicine or osteopathic medicine, hos-
11 pitals, residency programs in family medicine or pediat-
12 rics, or to a consortium of such entities, to enable such
13 entities to develop effective strategies for recruiting medi-
14 cal students interested in the practice of general medicine
15 and placing such students into general practice positions
16 upon graduation.

17 “(b) APPLICATION.—To be eligible to receive a grant
18 under this section, an entity of the type described in sub-
19 section (a) shall prepare and submit to the Secretary an
20 application at such time, in such manner, and containing
21 such information as the Secretary may require, including
22 assurances that the entity will use amounts received under
23 the grant in accordance with subsection (c).

24 “(c) USE OF FUNDS.—Amounts received under a
25 grant awarded under this section shall be used to fund

1 programs under which effective strategies are developed
 2 and implemented for recruiting medical students inter-
 3 ested in the practice of general medicine and placing such
 4 students into general practice positions upon graduation.

5 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
 6 are authorized to be appropriated to carry out this section,
 7 \$25,000,000 for each of the fiscal years 1994 through
 8 1998, and such sums as may be necessary for fiscal years
 9 thereafter.”.

10 **SEC. 505. PAYMENTS FOR DIRECT AND INDIRECT GRAD-**
 11 **UATE MEDICAL EDUCATION COSTS.**

12 (a) DIRECT MEDICAL EDUCATION COSTS.—Section
 13 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h))
 14 is amended—

15 (1) in paragraph (1)—

16 (A) by striking “hospitals for direct medi-
 17 cal education costs” and inserting “hospitals
 18 and public and private nonprofit entities with
 19 approved medical residency training programs
 20 for direct medical education costs”; and

21 (B) by striking “hospitals associated” and
 22 inserting “hospitals and public and private non-
 23 profit entities with approved medical residency
 24 training programs associated”;

25 (2) in paragraph (2)—

1 (A) in the matter preceding subparagraph
2 (A) by striking “each hospital” and inserting
3 “each hospital or public or private nonprofit
4 entity”;

5 (B) in subparagraph (A)—

6 (i) in the heading, by striking “HOS-
7 PITAL’S ”;

8 (ii) by striking “the hospital’s” and
9 inserting “the hospital’s or entity’s”; and

10 (iii) by striking “the hospital” and in-
11 serting “the hospital or entity”;

12 (C) in clause (ii) of subparagraph (B), by
13 striking “a hospital if the hospital’s” and in-
14 serting “a hospital or entity if the hospital’s or
15 entity’s”;

16 (D) in subparagraph (C), by striking “the
17 hospital” each place it appears and inserting
18 “the hospital or the entity”;

19 (E) in subparagraph (D), by striking “the
20 hospital” and inserting “the hospital or the
21 entity”; and

22 (F) in subparagraph (E), by striking “a
23 hospital” and inserting “a hospital or entity”;
24 (3) in paragraph (3)—

1 (A) in the heading, by striking “Hos-
2 PITAL”;

3 (B) in subparagraph (A),

4 (i) in the matter preceding clause (i),
5 by striking “hospital cost reporting period”
6 and inserting “cost reporting period of a
7 hospital or a public or private nonprofit
8 entity”; and

9 (ii) in clause (ii), by striking “the hos-
10 pital’s” and inserting “the hospital’s or
11 entity’s”;

12 (C) in subparagraph (B),

13 (i) in the matter preceding clause (i),
14 by striking “hospital cost reporting period”
15 and inserting “cost reporting period of a
16 hospital or a public or private nonprofit
17 entity”; and

18 (ii) in clauses (i) and (ii), by striking
19 “hospital’s” each place it appears and in-
20 serting “hospital’s or entity’s”; and

21 (D) in subparagraph (C), by striking “hos-
22 pital’s cost reporting period” and inserting
23 “cost reporting period of a hospital or a public
24 or private nonprofit entity”; and

25 (4) in paragraph (4)—

1 (A) in subparagraph (B), by striking “hos-
 2 pital” each place it appears and inserting “hos-
 3 pital or public or private nonprofit entity”; and

4 (B) in subparagraph (E), by striking “hos-
 5 pital” and inserting “hospital or public or pri-
 6 vate nonprofit entity”.

7 (b) INDIRECT MEDICAL EDUCATION COSTS.—

8 (1) IN GENERAL.—Section 1848 of such Act
 9 (42 U.S.C. 1395w-4) is amended—

10 (A) by redesignating subsection (j) as sub-
 11 section (k); and

12 (B) by inserting after subsection (i) the
 13 following new subsection:

14 “(j) PAYMENTS FOR INDIRECT GRADUATE MEDICAL
 15 EDUCATION COSTS.—

16 “(1) IN GENERAL.—The Secretary shall provide
 17 for an additional payment for indirect costs of medi-
 18 cal education in an amount equal to the product
 19 of—

20 “(A) the amount determined under sub-
 21 section (a)(1) for qualified physician’s services
 22 (as defined in paragraph (2)), and

23 “(B) the indirect teaching adjustment fac-
 24 tor determined in accordance with section
 25 1886(d)(5)(B)(ii) with ‘r’ equal to .2.

1 “(2) QUALIFIED PHYSICIAN’S SERVICES.—

2 “(A) IN GENERAL.—For purposes of para-
3 graph (1), the term ‘qualified physician’s serv-
4 ices’ means physician’s services (as defined in
5 subsection (k)(3)) that are—

6 “(i) provided during the course of
7 clinical training by medical residents in the
8 initial 3 years of postgraduate medical
9 training in approved medical residency
10 training programs in the fields of family
11 medicine (as defined by the Secretary),
12 general internal medicine (as defined by
13 the Secretary), and general pediatrics (as
14 defined by the Secretary), and

15 “(ii) provided at clinical training sites
16 affiliated with approved medical residency
17 training programs in family medicine, gen-
18 eral internal medicine, and general pedi-
19 atrics.

20 “(B) CERTAIN SERVICES EXCLUDED.—For
21 purposes of paragraph (1), the term ‘qualified
22 physician’s services’ shall not include services
23 provided during an inpatient hospital stay for
24 which payment is made under part A of this
25 title.”.

1 (2) CONFORMING AMENDMENTS.—Section 1848
2 of such Act (42 U.S.C. 1395w-4) is amended—

3 (A) in subsection (a)(1), by striking “sub-
4 section (j)(3)” and inserting “subsection
5 (k)(3)”;

6 (B) in subsection (b)(1), by striking “sub-
7 section (j)(2)” and inserting “(k)(2)”; and

8 (C) in subparagraphs (C) and (D) of sub-
9 section (d)(2), by striking “subsection (j)(1)”
10 and inserting “subsection (k)(1)”.

11 (c) SUBSECTION (d) HOSPITALS.—Section
12 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B))
13 is amended by adding at the end the following new clause:

14 “(v) In determining such adjustment the Sec-
15 retary shall count only those interns and residents
16 who are in the initial 3 years of postgraduate medi-
17 cal training.”.

18 (d) EFFECTIVE DATE.—The amendments made by
19 this section shall be effective for cost reporting periods be-
20 ginning on or after October 1, 1993.

1 **TITLE VI—MEDICARE PRE-**
2 **FERRED PROVIDER DEM-**
3 **ONSTRATION PROJECTS**

4 **SEC. 601. ESTABLISHMENT OF MEDICARE PRIMARY AND**
5 **SPECIALTY PREFERRED PROVIDER ORGANI-**
6 **ZATION DEMONSTRATION PROJECTS.**

7 (a) IN GENERAL.—Not later than 180 days after the
8 date of the enactment of this Act the Secretary of Health
9 and Human Services (hereafter referred to in this section
10 as the “Secretary”) shall provide for up to 10 demonstra-
11 tion projects to test the effectiveness of providing payment
12 under the medicare program under title XVIII of the So-
13 cial Security Act for primary and specialty procedures and
14 services (as determined appropriate by the Secretary) fur-
15 nished by preferred provider organizations. The dem-
16 onstration projects provided for under this section by the
17 Secretary shall—

18 (1) test the cost-effectiveness of preferred pro-
19 vider organizations furnishing primary and specialty
20 services in controlling the volume of such services
21 performed or ordered by physicians, and
22 nonphysician providers such as nurse practitioners,
23 clinical nurse specialists, certified nurse midwives,
24 certified registered nurse anesthetists, and physician

1 assistants, for which payment is made under title
2 XVIII of the Social Security Act;

3 (2) gather information on factors which may
4 encourage medicare beneficiaries to participate in a
5 preferred provider organizational network;

6 (3) examine the efficacy of permanently estab-
7 lishing managed care networks of primary and spe-
8 cialty service providers; and

9 (4) examine the factors necessary to increase
10 the quality and efficiency of primary and specialty
11 services furnished by preferred provider networks in
12 order to realize increased savings under the medi-
13 care program and to increase medicare beneficiary
14 participation in such networks.

15 (b) WAIVER OF MEDICARE REQUIREMENTS.—The
16 Secretary may waive such requirements of title XVIII of
17 the Social Security Act as the Secretary determines nec-
18 essary in conducting demonstration programs under this
19 section, including—

20 (1) coinsurance requirements;

21 (2) provider payment arrangements;

22 (3) beneficiary deductibles; and

23 (4) reimbursement for nonphysician providers.

24 (c) DURATION OF PROJECTS.—The demonstration
25 projects provided for under this section shall be conducted

1 for a period not to exceed 3 years from the date of the
2 enactment of this Act.

3 (d) REPORT.—Not later than 180 days after the date
4 of expiration of the demonstration projects conducted
5 under this section the Secretary shall report to the Con-
6 gress on the results of the demonstration projects includ-
7 ing recommendations for modifications in the medicare
8 program to increase the utilization of preferred provider
9 organizations in providing primary and specialty services
10 under such program.

11 **TITLE VII—COST CONTAINMENT**

12 **SEC. 701. NEW DRUG CLINICAL TRIALS PROGRAM.**

13 Part B of title IV of the Public Health Service Act
14 (42 U.S.C. 284 et seq.) is amended by adding at the end
15 the following new section:

16 **“SEC. 409A. NEW DRUG CLINICAL TRIALS PROGRAM.**

17 “(a) IN GENERAL.—The Director of the National In-
18 stitutes of Health (hereafter referred to in this section as
19 the ‘Director’) is authorized to establish and implement
20 a program for the conduct of clinical trials with respect
21 to new drugs and disease treatments determined to be
22 promising by the Director. In determining the drugs and
23 disease treatments that are to be the subject of such clini-
24 cal trials, the Director shall give priority to those drugs

1 and disease treatments targeted toward the diseases deter-
 2 mined—

3 “(1) to be the most costly to treat;

4 “(2) to have the highest mortality; or

5 “(3) to affect the greatest number of individ-
 6 uals.

7 “(b) AUTHORIZATION OF APPROPRIATIONS.—There
 8 are authorized to be appropriated to carry out this section,
 9 \$120,000,000 for fiscal year 1994, and such sums as may
 10 be necessary in each of the fiscal years 1995 through
 11 1998.”.

12 **SEC. 702. MEDICAL TREATMENT EFFECTIVENESS.**

13 (a) RESEARCH ON COST-EFFECTIVE METHODS OF
 14 HEALTH CARE.—Section 926 of the Public Health Service
 15 Act (42 U.S.C. 299c–5) is amended—

16 (1) in subsection (a), by striking “and
 17 \$115,000,000 for fiscal year 1993” and inserting
 18 “\$115,000,000 for fiscal year 1993, and such sums
 19 as may be necessary for each of the fiscal years
 20 1994 through 1997”; and

21 (2) by adding at the end the following new sub-
 22 section:

23 “(f) USE OF ADDITIONAL APPROPRIATIONS.—Within
 24 amounts appropriated under subsection (a) for each of the
 25 fiscal years 1993 through 1996 that are in excess of the

1 amounts appropriated under such subsection for fiscal
 2 year 1992, the Secretary shall give priority to expanding
 3 research conducted to determine the most cost-effective
 4 methods of health care and for developing and disseminat-
 5 ing new practice guidelines related to such methods. In
 6 utilizing such amounts, the Secretary shall give priority
 7 to diseases and disorders that the Secretary determines
 8 are the most costly to the United States and evidence a
 9 wide variation in current medical practice.”.

10 (b) RESEARCH ON MEDICAL TREATMENT OUT-
 11 COMES.—

12 (1) IMPOSITION OF TAX ON HEALTH INSUR-
 13 ANCE POLICIES.—

14 (A) IN GENERAL.—Chapter 36 of the In-
 15 ternal Revenue Code of 1986 (relating to cer-
 16 tain other excise taxes) is amended by adding
 17 at the end thereof the following new subchapter:

18 **“Subchapter G—Tax on Health Insurance**
 19 **Policies**

“Sec. 4501. Imposition of tax.

“Sec. 4502. Liability for tax.

20 **“SEC. 4501. IMPOSITION OF TAX.**

21 “(a) GENERAL RULE.—There is hereby imposed a
 22 tax equal to .001 cent on each dollar, or fractional part
 23 thereof, of the premium paid on a policy of health
 24 insurance.

1 “(b) DEFINITION.—For purposes of subsection (a),
 2 the term ‘policy of health insurance’ means any policy or
 3 other instrument by whatever name called whereby a con-
 4 tract of insurance is made, continued, or renewed with re-
 5 spect to the health of an individual or group of individuals.

6 **“SEC. 4502. LIABILITY FOR TAX.**

7 “The tax imposed by this subchapter shall be paid,
 8 on the basis of a return, by any person who makes, signs,
 9 issues, or sells any of the documents and instruments sub-
 10 ject to the tax, or for whose use or benefit the same are
 11 made, signed, issued or sold. The United States or any
 12 agency or instrumentality thereof shall not be liable for
 13 the tax.”.

14 (B) CONFORMING AMENDMENT.—The
 15 table of subchapters for chapter 36 of the Inter-
 16 nal Revenue Code of 1986 is amended by add-
 17 ing at the end thereof the following new item:

“SUBCHAPTER G. Tax on health insurance policies.”.

18 (2) ESTABLISHMENT OF TRUST FUND.—

19 (A) IN GENERAL.—Subchapter A of chap-
 20 ter 98 of such Code (relating to trust fund
 21 code) is amended by adding at the end thereof
 22 the following new section:

1 **“SEC. 9512. TRUST FUND FOR MEDICAL TREATMENT OUT-**
2 **COMES RESEARCH.**

“(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the ‘Trust Fund for Medical Treatment Outcomes Research’ (hereafter referred to in this section as the ‘Trust Fund’), consisting of such amounts as may be appropriated or credited to the Trust Fund as provided in this section or section 9602(b).

“(b) TRANSFERS TO TRUST FUND.—There is hereby appropriated to the Trust Fund an amount equivalent to the taxes received in the Treasury under section 4501 (relating to tax on health insurance policies).

14 “(c) DISTRIBUTION OF AMOUNTS IN TRUST FUND.—
15 On an annual basis the Secretary shall distribute the
16 amounts in the Trust Fund to the Secretary of Health
17 and Human Services. Such amounts shall be available to
18 the Secretary of Health and Human Services to pay for
19 research activities related to medical treatment out-
20 comes.”.

(B) CONFORMING AMENDMENT.—The table of sections for subchapter A of chapter 98 of such Code is amended by adding at the end thereof the following new item:

“Sec. 9512. Trust Fund for Medical Treatment Outcomes Research.”.

1 (3) EFFECTIVE DATE.—The amendments made
2 by this subsection shall apply to policies issued after
3 December 31, 1993.

4 **SEC. 703. HEALTH CARE COST CONTROL—EXPENDITURE**
5 **TARGETS.**

6 (a) IN GENERAL.—Not later than 1 year after the
7 date of the enactment of this Act, the Secretary of Health
8 and Human Services (hereafter referred to in this section
9 as the “Secretary”), after considering the recommenda-
10 tions of the Health Care Cost Control Advisory Committee
11 established under subsection (b), shall prepare and submit
12 to the appropriate committees of the Congress a report
13 concerning the establishment of national spending targets
14 for health care and health care services. Such report shall
15 contain the recommendations of the Secretary concerning
16 the feasibility—

17 (1) for controlling the cost of health care, re-
18 ducing cost shifting and maintaining the quality of
19 care;

20 (2) of establishing national targets for health
21 expenditures;

22 (3) of establishing national reimbursement tar-
23 gets for hospital services;

24 (4) of establishing national reimbursement tar-
25 gets for physicians’ services; and

1 (5) of establishing national reimbursement tar-
2 gets for prescription drug services.

3 (b) HEALTH CARE COST CONTROL ADVISORY COM-
4 MITTEE.—

5 (1) ESTABLISHMENT.—There shall be estab-
6 lished a Health Care Cost Control Advisory Commit-
7 tee (hereafter referred to in this subsection as the
8 “Committee”).

9 (2) MEMBERSHIP.—The Committee shall be
10 composed of 8 individuals appointed by the Sec-
11 retary, representing—

12 (A) physicians;

13 (B) hospitals;

14 (C) pharmacies;

15 (D) private insurers;

16 (E) State and local governments;

17 (F) employers;

18 (G) organized labor; and

19 (H) academia with expertise as a health
20 economist.

21 (3) COMPENSATION.—

22 (A) IN GENERAL.—Members of the Com-
23 mittee shall serve without compensation.

24 (B) EXPENSES REIMBURSED.—While away
25 from their homes or regular places of business

on the business of the Committee, the members of the Committee may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons employed intermittently in Government service.

(C) APPLICATION OF THE ACT.—The provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply with respect to the Committee.

(D) SUPPORT.—The Secretary shall supply such necessary office facilities, office supplies, support services, and related expenses as necessary to carry out the functions of the Committee.

TITLE VIII—LONG-TERM CARE

Subtitle A—Tax Treatment of Qualified Long-Term Care Insurance Policies

SEC. 801. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a

1 section or other provision of the Internal Revenue Code
2 of 1986.

3 **SEC. 802. DEFINITIONS OF QUALIFIED LONG-TERM CARE**
4 **INSURANCE AND PREMIUMS.**

5 (a) IN GENERAL.—Chapter 79 (relating to defini-
6 tions) is amended by adding at the end the following new
7 section:

8 **“SEC. 7705. QUALIFIED LONG-TERM CARE INSURANCE AND**
9 **PREMIUMS.**

10 “(a) QUALIFIED LONG-TERM CARE INSURANCE.—

11 “(1) IN GENERAL.—For purposes of this title,
12 the term ‘qualified long-term care insurance’ means
13 insurance under a policy or rider, issued by a quali-
14 fied issuer, which—

15 “(A) provides coverage for not less than 12
16 consecutive months for each covered person,

17 “(B) provides benefits on an expense in-
18 curred, indemnity, disability, prepaid, capita-
19 tion, or other basis,

20 “(C) provides benefits for—

21 “(i) medically necessary diagnostic,
22 preventive, therapeutic, rehabilitation, or
23 maintenance services,

24 “(ii) personal care services neces-
25 sitated by physical disability, or

1 “(iii) preventive, therapeutic, rehabili-
 2 tation, maintenance, or personal care serv-
 3 ices necessitated by cognitive impairment
 4 or the loss of functional capacity,
 5 when provided in a nursing home, a respite care
 6 facility, the home of the covered individual, or
 7 any other setting which is not an acute care
 8 unit of a hospital or a medical clinic, and

9 “(D) provides coverage for care described
 10 in subparagraph (C) (other than nursing home
 11 care) equal to not less than 47.5 percent of the
 12 national median cost of nursing care coverage,
 13 as determined by the Secretary.

14 “(2) QUALIFIED ISSUER.—For purposes of
 15 paragraph (1), the term ‘qualified issuer’ means any
 16 of the following, if subject to the jurisdiction and
 17 regulation of at least 1 State insurance department:

18 “(A) Private insurance company.

19 “(B) Fraternal benefit society.

20 “(C) Nonprofit health corporation.

21 “(D) Nonprofit hospital corporation.

22 “(E) Nonprofit medical service corpora-
 23 tion.

24 “(F) Prepaid health plan.

25 “(b) QUALIFIED LONG-TERM CARE PREMIUMS.—

1 “(1) IN GENERAL.—For purposes of this title,
 2 the term ‘qualified long-term care premiums’ means
 3 the amount paid during a taxable year for qualified
 4 long-term care insurance covering an individual, to
 5 the extent such amount does not exceed the limita-
 6 tion determined under the following table:

“In the case of an individual with an attained age before the close of the taxable year of:	The limitation is:
40 or less	\$200
More than 40 but not more than 50	375
More than 50 but not more than 60	750
More than 60 but not more than 70	1,600
More than 70	2,000.

7 “(2) INDEXING.—

8 “(A) IN GENERAL.—In the case of any
 9 taxable year beginning after December 31,
 10 1993, each dollar amount contained in para-
 11 graph (1) shall be increased by the medical care
 12 cost adjustment for such taxable year. If any
 13 increase determined under the preceding sen-
 14 tence is not a multiple of \$10, such increase
 15 shall be rounded to the nearest multiple of \$10.

16 “(B) MEDICAL CARE COST ADJUST-
 17 MENT.—For purposes of subparagraph (A), the
 18 medical care cost adjustment for any taxable
 19 year is the percentage (if any) by which—

20 “(i) the medical care component of
 21 the Consumer Price Index (as defined in

1 section 1(f)(5)) for August of the calendar
 2 year preceding the calendar year in which
 3 the taxable year begins, exceeds

4 “(ii) such component for August of
 5 1992.”.

6 (b) CLERICAL AMENDMENT.—The table of sections
 7 for chapter 79 is amended by inserting after the item re-
 8 lating to section 7704 the following new item:

“Sec. 7705. Qualified long-term care insurance and premiums.”.

9 **SEC. 803. TREATMENT OF QUALIFIED LONG-TERM CARE IN-**
 10 **SURANCE AS ACCIDENT AND HEALTH INSUR-**
 11 **ANCE FOR PURPOSES OF TAXATION OF IN-**
 12 **SURANCE COMPANIES.**

13 (a) IN GENERAL.—Section 818 (relating to other
 14 definitions and special rules) is amended by adding at the
 15 end the following new subsection:

16 “(g) QUALIFIED LONG-TERM CARE INSURANCE
 17 TREATED AS ACCIDENT OR HEALTH INSURANCE.—For
 18 purposes of this subchapter, any reference to
 19 noncancellable accident or health insurance contracts shall
 20 be treated as including a reference to qualified long-term
 21 care insurance.”.

22 (b) EFFECTIVE DATE.—The amendment made by
 23 this section shall apply to taxable years beginning after
 24 December 31, 1992.

1 **SEC. 804. TREATMENT OF ACCELERATED DEATH BENEFITS**
2 **UNDER LIFE INSURANCE CONTRACTS.**

3 (a) EXCLUSION OF AMOUNTS RECEIVED.—Section
4 101 (relating to certain death benefits) is amended by
5 adding at the end the following new subsection:

6 “(g) TREATMENT OF CERTAIN ACCELERATED
7 DEATH BENEFITS.—

8 “(1) IN GENERAL.—For purposes of this sec-
9 tion, any amount paid to an individual under a life
10 insurance contract on the life of an insured who is
11 a terminally ill individual, who has a dread disease,
12 or who has been permanently confined to a nursing
13 home shall be treated as an amount paid by reason
14 of the death of such insured.

15 “(2) TERMINALLY ILL INDIVIDUAL.—For pur-
16 poses of this subsection, the term ‘terminally ill indi-
17 vidual’ means an individual who has been certified
18 by a physician, licensed under State law, as having
19 an illness or physical condition which can reasonably
20 be expected to result in death in 12 months or less.

21 “(3) DREAD DISEASE.—For purposes of this
22 subsection, the term ‘dread disease’ means a medical
23 condition which has required or requires extraor-
24 dinary medical intervention without which the in-
25 sured would die, or a medical condition which would,

1 in the absence of extensive or extraordinary medical
2 treatment, result in a drastically limited life span.

3 “(4) PERMANENTLY CONFINED TO A NURSING
4 HOME.—For purposes of this subsection, an individ-
5 ual has been permanently confined to a nursing
6 home if the individual is presently confined to a
7 nursing home and has been certified by a physician,
8 licensed under State law, as having an illness or
9 physical condition which can reasonably be expected
10 to result in the individual remaining in a nursing
11 home for the rest of the individual’s life.”.

12 (b) TREATMENT OF QUALIFIED ACCELERATED
13 DEATH BENEFIT RIDERS AS LIFE INSURANCE.—

14 (1) IN GENERAL.—Section 818 (relating to
15 other definitions and special rules), as amended by
16 section 803, is amended by adding at the end the
17 following new subsection:

18 “(h) QUALIFIED ACCELERATED DEATH BENEFIT
19 RIDERS TREATED AS LIFE INSURANCE.—For purposes of
20 this part—

21 “(1) IN GENERAL.—Any reference to a life in-
22 surance contract shall be treated as including a ref-
23 erence to a qualified accelerated death benefit rider
24 on such contract.

1 “(2) QUALIFIED ACCELERATED DEATH BENE-
 2 FIT RIDER.—For purposes of this subsection, the
 3 term ‘qualified accelerated death benefit rider’
 4 means any rider or addendum on, or other provision
 5 of, a life insurance contract which provides for pay-
 6 ments to an individual on the life of an insured upon
 7 such insured becoming a terminally ill individual (as
 8 defined in section 101(g)(2)), incurring a dread dis-
 9 ease (as defined in section 101(g)(3)), or being per-
 10 manently confined to a nursing home (as defined in
 11 section 101(g)(4)).”.

12 (2) DEFINITIONS OF LIFE INSURANCE AND
 13 MODIFIED ENDOWMENT CONTRACTS.—

14 (A) RIDER TREATED AS QUALIFIED ADDI-
 15 TIONAL BENEFIT.—Subparagraph (A) of sec-
 16 tion 7702(f)(5) (relating to definition of life in-
 17 surance contract) is amended by striking “or”
 18 at the end of clause (iv), by redesignating
 19 clause (v) as clause (vi), and by inserting after
 20 clause (iv) the following new clause:

21 “(v) any qualified accelerated death
 22 benefit rider (as defined in section
 23 818(h)(2)), or any qualified long-term care
 24 insurance which reduces the death benefit,
 25 or”.

1 (B) TRANSITIONAL RULE.—For purposes
 2 of applying section 7702 or 7702A of the Inter-
 3 nal Revenue Code of 1986 to any contract (or
 4 determining whether either such section applies
 5 to such contract), the issuance of a rider or ad-
 6 dendum on, or other provision of, a life insur-
 7 ance contract permitting the acceleration of
 8 death benefits (as described in section 101(g))
 9 or for qualified long-term care insurance shall
 10 not be treated as a modification or material
 11 change of such contract.

12 (c) EFFECTIVE DATE.—The amendments made by
 13 this section shall apply to taxable years beginning after
 14 December 31, 1992.

15 **Subtitle B—Tax Incentives for Pur-**
 16 **chase of Qualified Long-Term**
 17 **Care Insurance**

18 **SEC. 811. CREDIT FOR QUALIFIED LONG-TERM CARE**
 19 **PREMIUMS.**

20 (a) GENERAL RULE.—Subpart C of part IV of sub-
 21 chapter A of chapter 1 (relating to refundable credits) is
 22 amended by redesignating section 35 as section 36 and
 23 by inserting after section 34 the following new section:

1 **“SEC. 35. LONG-TERM CARE INSURANCE CREDIT.**

2 “(a) GENERAL RULE.—In the case of an individual,
3 there shall be allowed as a credit against the tax imposed
4 by this subtitle for the taxable year an amount equal to
5 the applicable percentage of the qualified long-term care
6 premiums (as defined in section 7705(b)) paid during such
7 taxable year for such individual or the spouse of such
8 individual.

9 “(b) APPLICABLE PERCENTAGE.—

10 “(1) IN GENERAL.—For purposes of this sec-
11 tion, the term ‘applicable percentage’ means 28 per-
12 cent reduced (but not below zero) by 1 percentage
13 point for each \$1,000 (or fraction thereof) by which
14 the taxpayer’s adjusted gross income for the taxable
15 year exceeds the base amount.

16 “(2) BASE AMOUNT.—For purposes of para-
17 graph (1) the term ‘base amount’ means—

18 “(A) except as otherwise provided in this
19 paragraph, \$25,000,

20 “(B) \$40,000 in the case of a joint return,
21 and

22 “(C) zero in the case of a taxpayer who—

23 “(i) is married at the close of the tax-
24 able year (within the meaning of section
25 7703) but does not file a joint return for
26 such taxable year, and

1 “(ii) does not live apart from his or
 2 her spouse at all times during the taxable
 3 year.

4 “(c) COORDINATION WITH MEDICAL EXPENSE DE-
 5 Duction.—Any amount allowed as a credit under this
 6 section shall not be taken into account under section
 7 213.”.

8 (b) CLERICAL AMENDMENT.—The table of sections
 9 for subpart C of part IV of subchapter A of chapter 1
 10 is amended by striking the item relating to section 35 and
 11 inserting the following:

“Sec. 35. Long-term care insurance credit.
 “Sec. 36. Overpayments of tax.”.

12 (c) EFFECTIVE DATE.—The amendments made by
 13 this section shall apply to taxable years beginning after
 14 December 31, 1992.

15 **SEC. 812. DEDUCTION FOR EXPENSES RELATING TO QUALI-**
 16 **FIED LONG-TERM CARE.**

17 (a) DEDUCTION FOR QUALIFIED LONG-TERM CARE
 18 PREMIUMS.—Subparagraph (C) of section 213(d)(1) (re-
 19 lating to the definition of medical care) is amended by
 20 striking “aged)” and inserting the following: “aged, and
 21 amounts paid as qualified long-term care premiums (as
 22 defined in section 7705(b))”.

23 (b) DEDUCTION FOR LONG-TERM CARE EXPENSES
 24 FOR PARENT OR GRANDPARENT.—Section 213 (relating

1 to deduction for medical expenses) is amended by adding
 2 at the end the following new subsection:

3 “(g) SPECIAL RULE FOR CERTAIN LONG-TERM CARE
 4 EXPENSES.—For purposes of subsection (a), the term ‘de-
 5 pendent’ shall include any parent or grandparent of the
 6 taxpayer for whom the taxpayer has long-term care ex-
 7 penses described in section 7705(a)(1)(C), but only to the
 8 extent of such expenses.”.

9 (c) EFFECTIVE DATE.—The amendments made by
 10 this section shall apply to taxable years beginning after
 11 December 31, 1992.

12 **SEC. 813. EXCLUSION FROM GROSS INCOME OF BENEFITS**
 13 **RECEIVED UNDER QUALIFIED LONG-TERM**
 14 **CARE INSURANCE.**

15 (a) IN GENERAL.—Section 105 (relating to amounts
 16 received under accident and health plans) is amended by
 17 adding at the end the following new subsection:

18 “(j) SPECIAL RULES RELATING TO QUALIFIED
 19 LONG-TERM CARE INSURANCE.—For purposes of section
 20 104, this section, and section 106—

21 “(1) BENEFITS TREATED AS PAYABLE FOR
 22 SICKNESS, ETC.—Any benefit received through quali-
 23 fied long-term care insurance shall be treated as
 24 amounts received through accident or health insur-
 25 ance for personal injuries or sickness.

1 “(2) EXPENSES FOR WHICH REIMBURSEMENT
2 PROVIDED UNDER QUALIFIED LONG-TERM CARE IN-
3 SURANCE TREATED AS INCURRED FOR MEDICAL
4 CARE OR FUNCTIONAL LOSS.—

5 “(A) EXPENSES.—Expenses incurred by
6 the taxpayer or spouse, or by the dependent,
7 parent, or grandparent of either, to the extent
8 of benefits paid under qualified long-term care
9 insurance shall be treated for purposes of sub-
10 section (b) as incurred for medical care (as de-
11 fined in section 213(d)).

12 “(B) BENEFITS.—Benefits received under
13 qualified long-term care insurance shall be
14 treated for purposes of subsection (c) as pay-
15 ment for the permanent loss or loss of use of
16 a member or function of the body or the perma-
17 nent disfigurement of the taxpayer or spouse,
18 or the dependent, parent, or grandparent of
19 either.

20 “(3) REFERENCES TO ACCIDENT AND HEALTH
21 PLANS.—

22 “(A) IN GENERAL.—Any reference to an
23 accident or health plan shall be treated as in-
24 cluding a reference to a plan providing qualified
25 long-term care insurance.

1 “(B) LIMITATION.—Subparagraph (A)
 2 shall apply for purposes of section 106 only to
 3 the extent of qualified long-term care premiums
 4 (as defined in section 7705(b)).”.

5 (b) EFFECTIVE DATE.—The amendment made by
 6 this section shall apply to taxable years beginning after
 7 December 31, 1992.

8 **SEC. 814. EMPLOYER DEDUCTION FOR CONTRIBUTIONS**
 9 **MADE FOR LONG-TERM CARE INSURANCE.**

10 (a) IN GENERAL.—Subparagraph (B) of section
 11 404(b)(2) (relating to plans providing certain deferred
 12 benefits) is amended to read as follows:

13 “(B) EXCEPTIONS.—Subparagraph (A)
 14 shall not apply to—

15 “(i) any benefit provided through a
 16 welfare benefit fund (as defined in section
 17 419(e)), or

18 “(ii) any benefit provided under quali-
 19 fied long-term care insurance through the
 20 payment (in whole or in part) of qualified
 21 long-term care premiums (as defined in
 22 section 7705(b)) by an employer pursuant
 23 to a plan for its active or retired employ-
 24 ees, but only if any refund or premium is

1 applied to reduce the future costs of the
 2 plan or increase benefits under the plan.”.

3 (b) EFFECTIVE DATE.—The amendment made by
 4 this section shall apply to taxable years beginning after
 5 December 31, 1992.

6 **SEC. 815. INCLUSION OF QUALIFIED LONG-TERM CARE IN-**
 7 **SURANCE IN CAFETERIA PLANS.**

8 (a) IN GENERAL.—Paragraph (2) of section 125(d)
 9 (relating to the exclusion of deferred compensation) is
 10 amended by adding at the end the following new
 11 subparagraph:

12 “(D) EXCEPTION FOR LONG-TERM CARE
 13 INSURANCE CONTRACTS.—For purposes of sub-
 14 paragraph (A), amounts paid or incurred for
 15 any long-term care insurance contract shall not
 16 be treated as deferred compensation to the ex-
 17 tent section 404(b)(2)(A) does not apply to
 18 such amounts by reason of section
 19 404(b)(2)(B)(ii).”.

20 (b) CONFORMING AMENDMENT.—Subsection (f) of
 21 section 125 (relating to qualified benefits) is amended by
 22 striking “and such term includes” and inserting the fol-
 23 lowing: “, qualified long-term care insurance, and”.

1 (c) EFFECTIVE DATE.—The amendments made by
 2 this section shall apply to taxable years beginning after
 3 December 31, 1992.

4 **SEC. 816. EXCLUSION FROM GROSS INCOME FOR AMOUNTS**
 5 **WITHDRAWN FROM INDIVIDUAL RETIRE-**
 6 **MENT PLANS AND SECTION 401(k) PLANS FOR**
 7 **QUALIFIED LONG-TERM CARE PREMIUMS**
 8 **AND EXPENSES.**

9 (a) IN GENERAL.—Part III of subchapter B of chap-
 10 ter 1 (relating to items specifically excluded from gross
 11 income) is amended by redesignating section 136 as sec-
 12 tion 137 and by inserting after section 135 the following
 13 new section:

14 **“SEC. 136. DISTRIBUTIONS FROM INDIVIDUAL RETIREMENT**
 15 **PLANS AND SECTION 401(k) PLANS FOR**
 16 **QUALIFIED LONG-TERM CARE PREMIUMS**
 17 **AND EXPENSES.**

18 “(a) GENERAL RULE.—In the case of an individual,
 19 gross income shall not include any qualified distribution.

20 “(b) QUALIFIED DISTRIBUTION.—For purposes of
 21 this section, the term ‘qualified distribution’ means any
 22 amount distributed from an individual retirement plan or
 23 a section 401(k) plan during the taxable year if such
 24 amount is used during such year—

1 “(1) to pay qualified long-term care premiums
 2 (as defined in section 7705(b)) for the benefit of the
 3 payee or distributee or the spouse of the payee or
 4 distributee, if such policy may not be surrendered
 5 for cash, or

6 “(2) to pay long-term care expenses (as
 7 described in section 7705(a)(1)(C)) of such an
 8 individual.

9 “(c) SPECIAL RULES.—For purposes of this sec-
 10 tion—

11 “(1) QUALIFIED DISTRIBUTIONS FROM IRA
 12 DEEMED MADE FIRST FROM DESIGNATED NON-
 13 DEDUCTIBLE CONTRIBUTIONS.—For purposes of
 14 section 72, qualified distributions from an individual
 15 retirement plan shall be treated as made from des-
 16 ignated nondeductible contributions to the extent
 17 thereof and then from other amounts.

18 “(2) SPECIAL RULES FOR SECTION 401(k)
 19 PLANS.—

20 “(A) QUALIFIED DISTRIBUTIONS FROM
 21 SECTION 401(k) PLAN MAY NOT EXCEED ELEC-
 22 TIVE DEFERRALS.—This section shall not apply
 23 to any distribution from a section 401(k) plan
 24 to the extent the aggregate amount of such dis-
 25 tributions for the use described in subsection

1 (a) exceeds the aggregate employer contribu-
 2 tions made pursuant to the employee's election
 3 under section 401(k)(2) (and the income
 4 thereon).

5 “(B) WITHDRAWALS NOT TO CAUSE DIS-
 6 QUALIFICATION.—A plan shall not be treated as
 7 failing to satisfy the requirements of section
 8 401, and an arrangement shall not be treated
 9 as failing to be a qualified cash or deferred ar-
 10 rangement (as defined in section 401(k)(2)),
 11 merely because under the plan or arrangement
 12 distributions are permitted which are excludable
 13 from gross income by reason of this section.

14 “(d) SECTION 401(k) PLAN.—For purposes of this
 15 section, the term ‘section 401(k) plan’ means any em-
 16 ployer plan which meets the requirements of section
 17 401(a) and which includes a qualified cash or deferred ar-
 18 rangement (as defined in section 401(k)).”.

19 (b) CONFORMING AMENDMENTS.—

20 (1) Subsection (k) of section 401 is amended by
 21 adding at the end the following new paragraph:

22 “(11) CROSS REFERENCE.—

“For provision permitting tax-free withdrawals
 for qualified long-term care premiums and ex-
 penses, see section 136.”.

23 (2) Subsection (d) of section 408 is amended by
 24 adding at the end the following new paragraph:

1 “(8) CROSS REFERENCE.—

“For provision permitting tax-free withdrawals for qualified long-term care premiums and expenses, see section 136.”.

2 (3) The table of sections for such part III is
3 amended by striking the item relating to section 136
4 and inserting the following new items:

“Sec. 136. Distributions from individual retirement plans and section 401(k) plans for qualified long-term care premiums and expenses.

“Sec. 137. Cross references to other Acts.”.

5 (c) INCREASE IN AMOUNT OF DEDUCTIBLE CON-
6 TRIBUTIONS TO INDIVIDUAL RETIREMENT PLANS.—

7 (1) IN GENERAL.—Subparagraph (A) of section
8 219(b)(1) (relating to maximum amount of deduc-
9 tion) is amended by striking “\$2,000” and inserting
10 “\$4,000”.

11 (2) SPOUSAL IRA.—Paragraph (2) of section
12 219(c) (relating to special rules for certain married
13 individuals) is amended by striking “\$2,250” and
14 “\$2,000” and inserting “\$4,500” and “\$4,000”,
15 respectively.

16 (3) CONFORMING AMENDMENTS.—

17 (A) Section 408(a)(1) is amended by strik-
18 ing “in excess of \$2,000 on behalf of any indi-
19 vidual” and inserting “on behalf of any individ-
20 ual in excess of the amount in effect for such
21 taxable year under section 219(b)(1)(A)”.

1 (B) Section 408(b)(2)(B) is amended by
2 striking “\$2,000” and inserting “the dollar
3 amount in effect under section 219(b)(1)(A)”.

4 (C) Section 408(j) is amended by striking
5 “\$2,000”.

6 (d) EFFECTIVE DATE.—The amendments made by
7 this section shall apply to taxable years beginning after
8 December 31, 1992.

9 **SEC. 817. EXCLUSION FROM GROSS INCOME FOR AMOUNTS**
10 **RECEIVED ON CANCELLATION OF LIFE IN-**
11 **SURANCE POLICIES AND USED FOR QUALI-**
12 **FIED LONG-TERM CARE INSURANCE.**

13 (a) IN GENERAL.—

14 (1) EXCLUSION FROM GROSS INCOME.—

15 (A) IN GENERAL.—Part III of subchapter
16 B of chapter 1 (relating to items specifically ex-
17 cluded from gross income), as amended by sec-
18 tion 216, is further amended by redesignating
19 section 137 as section 138 and by inserting
20 after section 136 the following new section:

1 **“SEC. 137. AMOUNTS RECEIVED ON CANCELLATION, ETC.**
 2 **OF LIFE INSURANCE CONTRACTS AND USED**
 3 **TO PAY PREMIUMS FOR QUALIFIED LONG-**
 4 **TERM CARE INSURANCE.**

5 “No amount (which but for this section would be in-
 6 cludible in the gross income of an individual) shall be in-
 7 cluded in gross income on the whole or partial surrender,
 8 cancellation, or exchange of any life insurance contract
 9 during the taxable year if—

10 “(1) such individual has attained age 59½ on
 11 or before the date of the transaction, and

12 “(2) the amount otherwise includible in gross
 13 income is used during such year to pay for any pol-
 14 icy of qualified long-term care insurance which—

15 “(A) is for the benefit of such individual or
 16 the spouse of such individual if such spouse has
 17 attained age 59½ on or before the date of the
 18 transaction, and

19 “(B) may not be surrendered for cash.”.

20 (B) CLERICAL AMENDMENT.—The table of
 21 sections for such part III is amended by strik-
 22 ing the last item and inserting the following
 23 new items:

“Sec. 137. Amounts received on cancellation, etc. of life insurance
 contracts and used to pay premiums for qualified
 long-term care insurance.

“Sec. 138. Cross references to other Acts.”.

1 (2) CERTAIN EXCHANGES NOT TAXABLE.—Sub-
 2 section (a) of section 1035 (relating to certain ex-
 3 changes of insurance contracts) is amended by strik-
 4 ing the period at the end of paragraph (3) and in-
 5 serting “; or”, and by adding at the end the follow-
 6 ing new paragraph:

7 “(4) in the case of an individual who has at-
 8 tained age 59½, a contract of life insurance or an
 9 endowment or annuity contract for a policy of quali-
 10 fied long-term care insurance, if such policy may not
 11 be surrendered for cash.”.

12 (b) EFFECTIVE DATE.—The amendments made by
 13 this section shall apply to taxable years beginning after
 14 December 31, 1992.

15 **SEC. 818. USE OF GAIN FROM SALE OF PRINCIPAL RESI-**
 16 **DENCE FOR PURCHASE OF QUALIFIED LONG-**
 17 **TERM HEALTH CARE INSURANCE.**

18 (a) IN GENERAL.—Subsection (d) of section 121 (re-
 19 lating to 1-time exclusion of gain from sale of principal
 20 residence by individual who has attained age 55) is
 21 amended by adding at the end the following new
 22 paragraph:

23 “(10) ELIGIBILITY OF HOME EQUITY CONVER-
 24 SION SALE-LEASEBACK TRANSACTION FOR
 25 EXCLUSION.—

1 “(A) IN GENERAL.—For purposes of this
2 section, the term ‘sale or exchange’ includes a
3 home equity conversion sale-leaseback
4 transaction.

5 “(B) HOME EQUITY CONVERSION SALE-
6 LEASEBACK TRANSACTION.—For purposes of
7 subparagraph (A), the term ‘home equity con-
8 version sale-leaseback’ means a transaction in
9 which—

10 “(i) the seller-lessee—

11 “(I) has attained the age of 55
12 before the date of the transaction,

13 “(II) sells property which during
14 the 5-year period ending on the date
15 of the transaction has been owned and
16 used as a principal residence by such
17 seller-lessee for periods aggregating 3
18 years or more,

19 “(III) uses a portion of the pro-
20 ceeds from such sale to purchase a
21 policy of qualified long-term care in-
22 surance, which policy may not be sur-
23 rendered for cash,

1 “(IV) obtains occupancy rights in
2 such property pursuant to a written
3 lease requiring a fair rental, and

4 “(V) receives no option to repur-
5 chase the property at a price less than
6 the fair market price of the property
7 unencumbered by any leaseback at the
8 time such option is exercised, and

9 “(ii) the purchaser-lessor—

10 “(I) is a person,

11 “(II) is contractually responsible
12 for the risks and burdens of owner-
13 ship and receives the benefits of own-
14 ership (other than the seller-lessee’s
15 occupancy rights) after the date of
16 such transaction, and

17 “(III) pays a purchase price for
18 the property that is not less than the
19 fair market price of such property en-
20 cumbered by a leaseback, and taking
21 into account the terms of the lease.

22 “(C) ADDITIONAL DEFINITIONS.—For pur-
23 poses of subparagraph (B)—

24 “(i) OCCUPANCY RIGHTS.—The term
25 ‘occupancy rights’ means the right to oc-

1 cupy the property for any period of time,
 2 including a period of time measured by the
 3 life of the seller-lessee on the date of the
 4 sale-leaseback transaction (or the life of
 5 the surviving seller-lessee, in the case of
 6 jointly held occupancy rights), or a periodic
 7 term subject to a continuing right of re-
 8 newal by the seller-lessee (or by the surviv-
 9 ing seller-lessee, in the case of jointly held
 10 occupancy rights).

11 “(ii) FAIR RENTAL.—The term ‘fair
 12 rental’ means a rental for any subsequent
 13 year which equals or exceeds the rental for
 14 the first year of a sale-leaseback
 15 transaction.”.

16 (b) EFFECTIVE DATE.—The amendment made by
 17 this section shall apply to sales after December 31, 1992,
 18 in taxable years beginning after such date.

19 **Subtitle C—Medicaid Amendments**

20 **SEC. 821. EXPANSION OF MEDICAID ELIGIBILITY FOR** 21 **LONG-TERM CARE BENEFITS.**

22 (a) IN GENERAL.—Title XIX of the Social Security
 23 Act (42 U.S.C. 1396 et seq.) is amended by adding at
 24 the end the following new section:

1 “ELIGIBILITY FOR LONG-TERM CARE BENEFITS

2 “SEC. 1931. (a) ELIGIBILITY FOR NURSING FACIL-
3 ITY SERVICES.—Any individual—

4 “(1) who is 65 years of age or older,

5 “(2) who has resources (including resources of
6 the individual’s spouse) which do not exceed the re-
7 source limitation specified in subsection (c)(1),

8 “(3) who is not otherwise eligible for medical
9 assistance for nursing facility services under this
10 title, and

11 “(4) who has been provided 30 months of nurs-
12 ing facility services (during a period in which the in-
13 dividual required the level of care provided in a
14 nursing facility) during the previous 48 months (or,
15 with respect to the application of subsection (e), 72
16 months),

17 is eligible, notwithstanding any other provisions of this
18 title, for medical assistance under this title for nursing
19 facility services so long as the individual continues to meet
20 the requirements of this subsection (other than paragraph
21 (4)) and is confined to a nursing facility or otherwise re-
22 quires the same level of care as is provided in a nursing
23 facility.

24 “(b) ELIGIBILITY FOR HOME AND COMMUNITY-
25 BASED CARE.—Any individual—

1 “(1) who is 65 years of age or older,

2 “(2) who has resources (including resources of
3 the individual’s spouse) which do not exceed the re-
4 source limitation specified in subsection (c)(1), and

5 “(3) who is not otherwise eligible for medical
6 assistance for home and community-based long-term
7 care under this title,

8 is eligible, notwithstanding any other provisions of this
9 title, for medical assistance under this title for home and
10 community-based long-term care so long as the individual
11 continues to meet the requirements of this subsection and
12 requires the same level of care as is provided in a nursing
13 facility.

14 “(c) RESOURCE LIMITATION.—

15 “(1) IN GENERAL.—For purposes of this sec-
16 tion, the resource limitation specified in this sub-
17 section is \$500,000, increased, for each year after
18 1993, by the percentage increase in the Consumer
19 Price Index for All Urban Consumers (all items;
20 U.S. city average) from July 1992 to July of the
21 previous year, rounded (if not a multiple of \$1,000)
22 to the nearest \$1,000.

23 “(2) CERTAIN PERSONAL PROPERTY NOT IN-
24 CLUDED.—Personal property items with a fair mar-
25 ket value less than \$5,000 in the aggregate shall not

1 be included in any calculation of resources under
2 subsections (a) and (b) which are subject to the re-
3 source limitation specified in paragraph (1).

4 “(d) TREATMENT OF LEVEL OF CARE.—

5 “(1) IN GENERAL.—For purposes of sub-
6 sections (a) and (b), an individual is considered to
7 require the level of care provided in a nursing facil-
8 ity if the individual cannot perform (without sub-
9 stantial human assistance) at least 3 activities of
10 daily living or needs substantial human assistance
11 because of cognitive or other mental impairment (in-
12 cluding Alzheimer’s disease).

13 “(2) ACTIVITIES OF DAILY LIVING DEFINED.—

14 The ‘activities of daily living’ referred to in para-
15 graph (1) are the following: eating, bathing, dress-
16 ing, toileting, and transferring in and out of a bed
17 or in and out of a chair.

18 “(e) SUBSTITUTION OF EXPENSES INCURRED FOR
19 QUALIFIED HOME CARE FOR MONTHS IN NURSING
20 FACILITY.—

21 “(1) IN GENERAL.—In determining whether an
22 individual has been provided 30 months of nursing
23 facility services under subsection (a)(4), expenses in-
24 curred (whether paid for by insurance, themselves,
25 or relatives but not including expenses for which

1 payment is made under this title, by the Department
 2 of Veterans Affairs, the Department of Defense, or
 3 other Federal programs) for qualified home care (as
 4 defined in paragraph (3)) shall be taken into ac-
 5 count in the manner specified in paragraph (2).

6 “(2) CONVERTING EXPENSES TO MONTHS.—
 7 Expenses described in paragraph (1) shall be con-
 8 verted to months of nursing facility services by di-
 9 viding such expenses by the national median month-
 10 ly cost (as determined by the Secretary, and using
 11 a weighted average for both public and private nurs-
 12 ing facilities) for nursing facility services in the
 13 month in which the expenses are incurred.

14 “(3) QUALIFIED HOME CARE DEFINED.—In
 15 this subsection, the term ‘qualified home care’
 16 means home and community-based services described
 17 in section 1915(d).”.

18 (b) CONFORMING AMENDMENTS.—Section 1902(a)
 19 of such Act (42 U.S.C. 1396a(a)), as amended by section
 20 302, is further amended—

21 (1) in paragraph (10)—

22 (A) in clause (i) of subparagraph (A), by
 23 striking “or” at the end of subclause (VI), by
 24 striking the semicolon at the end of subclause

(VII) and inserting “, or”, and by adding at the end the following:

“(VIII) who are described in sub-sections (a) and (b) of section 1931;”;
and

(B) in the matter following subparagraph (F)—

(i) by striking “; and (XI)” and inserting “, (XI);

(ii) by striking “, and (XI)” and inserting “, (XII); and

(iii) by inserting before the semicolon at the end the following: “, and (XIII) the making available of medical assistance for certain nursing facility services and home and community-based long-term care in accordance with section 1931 shall not, by reason of this paragraph, require such assistance to be made available to other individuals”;

(2) in paragraph (59), by striking “; and” and inserting a semicolon,

(3) in paragraph (60), by striking the period at the end and inserting “; and”, and

1 (4) by adding at the end the following new
2 paragraph:

3 “(61) provides for medical assistance for cer-
4 tain nursing facility services and home and commu-
5 nity-based long-term care in accordance with section
6 1931.”.

7 **SEC. 822. EFFECTIVE DATE.**

8 (a) IN GENERAL.—The amendments made by this
9 subtitle apply (except as provided under subsection (b))
10 to payments under title XIX of the Social Security Act
11 for calendar quarters beginning on or after 1 year after
12 the date of the enactment of this Act, without regard to
13 whether regulations to implement such amendments are
14 promulgated by such date.

15 (b) DELAY PERMITTED IF STATE LEGISLATION RE-
16 QUIRED.—In the case of a State plan for medical assist-
17 ance under title XIX of the Social Security Act which the
18 Secretary of Health and Human Services determines re-
19 quires State legislation (other than legislation authorizing
20 or appropriating funds) in order for the plan to meet the
21 additional requirements imposed by the amendments made
22 by this subtitle, the State plan shall not be regarded as
23 failing to comply with the requirements of such title solely
24 on the basis of its failure to meet these additional require-
25 ments before the first day of the first calendar quarter

1 beginning after the close of the first regular session of the
 2 State legislature that begins after the date of the enact-
 3 ment of this Act. For purposes of the previous sentence,
 4 in the case of a State that has a 2-year legislative session,
 5 each year of such session shall be deemed to be a separate
 6 regular session of the State legislature.

7 (c) TRANSITION.—In applying the amendments made
 8 by this subtitle, only months beginning after the date of
 9 the enactment of this Act may be counted toward meeting
 10 the 30-month deductible described in section 1931(a)(4)
 11 of the Social Security Act, as added by this subtitle.



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